HOSPITAL Management

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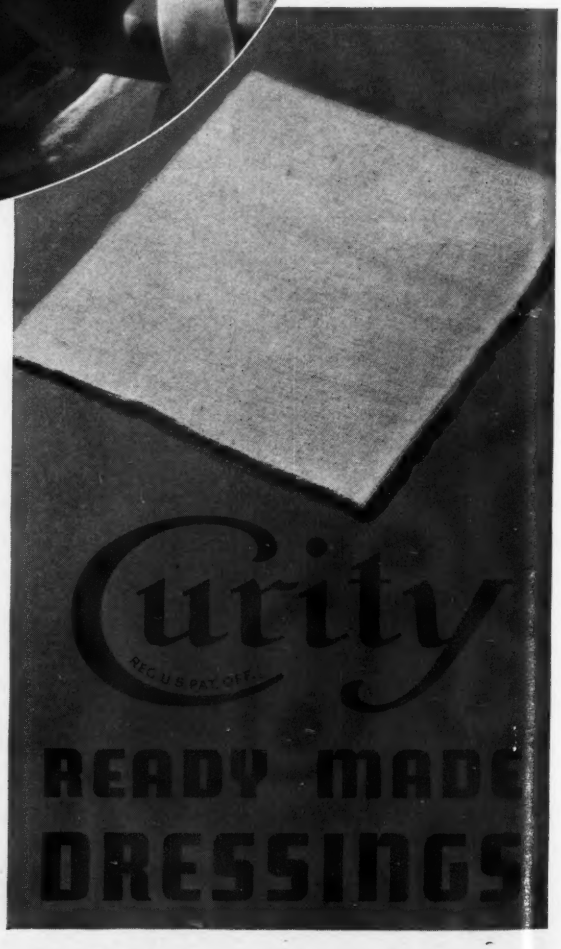

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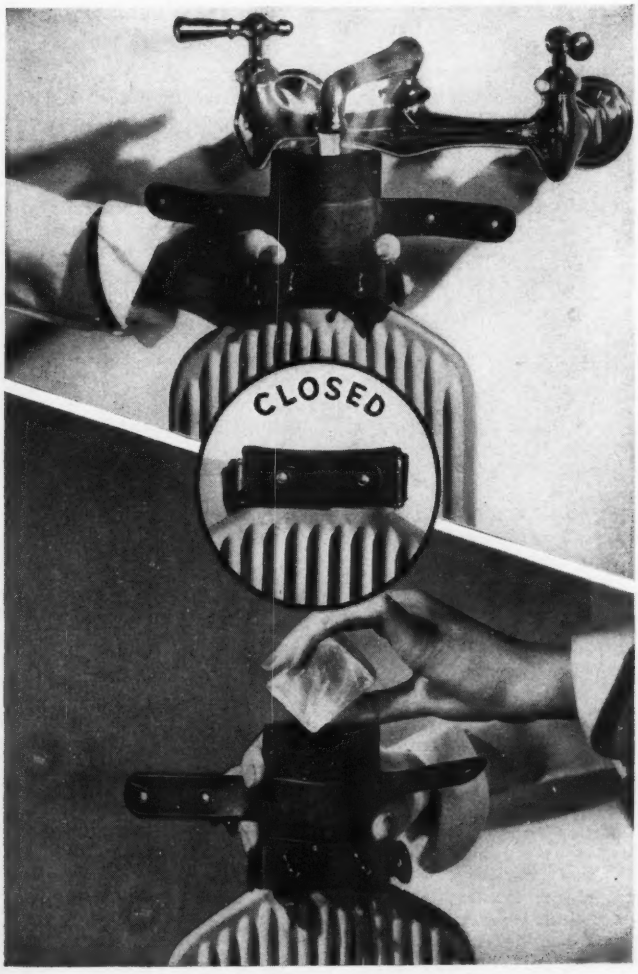

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Lines & Letters

Collection of Hospital Accounts

The perennial question of collection of hospital accounts is receiving the attention of the Chicago Hospital Council. It is proposed to organize a Central Credit and Collection agency, controlled by the Council. In the discussion of the proposed agency the following points are up for consideration.

1—Admission of the patient. Information necessary for future collection effort will be secured at this time. On discharge, a copy of the form used will be filed with the Council to be entered in a central credit file.

2—Post-hospitalization procedure. The hospital will make systematized effort to collect for a period of 90 days, after which, if payment has not been made or arranged, the account will be turned over to the central collection service.

3—Central collection service. The account will be handled by persons who will make collection effort in such a manner as to avoid, if possible, endangering the goodwill toward the hospital.

a—A duplicate statement will be prepared and sent to the hospital for verification.

b—A letter will be mailed to the patient advising him that the account has been turned over to the Central Collection Agency. During the ten days which follow this letter investigators will check the economic resources of the patient and an attempt will be made to establish a personal contact.

c—Patients who may require a budget plan for payment will be accommodated. In those cases in which the patient is considered able to pay in full, collection will be pushed.

d—Matters of special policy involving adjustments will be dealt with on authorization of the hospital.

4—Legal procedure. If other means fail, the account will be turned over to an attorney, if considered collectible, and on written authorization of the hospital.

5—Reports and remittances. After the collection service has been in operation for a period of 90 days, reports, with remittances, will be made to the hospital. Should the patient elect to pay the hospital direct, this will be allowed and the collection agency notified of the payment.

6—Fees. The fee for collection has been set at 25 per cent (to include legal expense), but it is provided that, since the organization is nonprofit in character, if this figure more than covers reasonable allowance any surplus may be returned at the end of each year to the hospitals concerned in accumulating the surplus.

The scheme appears to be a practical one and to have many advantages. The key to success will be in following strict business methods and in the selection of personnel who have had experience in collection and are also familiar with the hospital and its problems. We wish the Council every success and await the ultimate outcome with interest.

●

The School of Nursing In The Small Hospital

A correspondent writes asking several questions regarding the training of nurses in the small hospital. The letter opens the entire question of nurse education, which we are not disposed to discuss at this time, but there are a few points which are extremely pertinent.

The State Board "is making an effort to raise the requirements of training schools for nurses to such an extent that it would be almost impossible for any hospital in the State to comply."

Educational standards have been established by the National League of Nursing education and, while this body does not have authority to enforce its standards, they are being very generally accepted. Regardless of whether the hospital agrees with accepted standards or not, it must conform to them. One reason alone is sufficient. The hospital school of nursing cannot be considered from the local angle only. Nurses are graduated who may wish to follow their profession in distant fields, but if the standard of the hospital from which they graduated is low they do not qualify for other state boards and an injustice has been done them.

Adoption of the higher standards "would necessitate the purchase of a great deal of equipment and supplies which would work a great hardship on the small hospital."

Quite true, but equipment is a necessity for good teaching. Some hospitals have found it advantageous to arrange with a junior college or similar institution for the teaching of chemistry, dietetics and other theory.

An allied item of expense, not mentioned by the correspondent, is affiliation. The small hospital must arrange affiliation for training in the nursing of several types of cases, and the expense is great.

"In case the smaller hospitals are unable to comply with these requirements, would the larger hospitals be able to supply the demand for nurses?"

This involves the question of supply and demand, and the point raised appears to be well taken. It is true that the Grading Committee, only a few years ago, reported a surplus of graduate nurses, but during the past year we have been hearing of a shortage of nurses at some points. This may be due to an actual shortage or there may be improper distribution. We would like to have information as to the availability of nurses for hospital service from different sections of the country.

●

Taxing the Voluntary Hospital

It would appear that this is not the only country in which hospitals which are privately owned but are furnishing free service to indigent patients feel that they are unjustly taxed. The following is quoted from *The Hospital*, a British publication.

"It seems very hard that an institution which is really saving the rates (taxes) of the town should have to pay rates for the privilege of doing so. The above protest will be echoed by all those concerned with the administration of our voluntary hospitals and by their supporters."

The care of the indigent is recognized as a state responsibility and in many cases this responsibility is assumed by privately owned hospitals with either no compensation or at a rate below cost. Yet, in many of the states these hospitals are not tax exempt. It certainly appears unjust that a hospital which is supporting itself without governmental assistance and is relieving the government from a certain amount of expenditure for the care of those who are not able to pay, should also be required to pay taxes.

The Editors

LYSOL PLAYS STAR ROLE IN FLOOD DRAMA!

International News Photo

Awaiting stork in flood refuge: Wheeling, W. Va.... The Market Auditorium, Wheeling's refuge for flood sufferers, where a temporary lying-in hospital was set up for Mrs. Carrie Rollison who expected baby hourly. Left to right, male nurse, Warren Metzdorf, Mrs. Rollison, Jackie and Betty Rollison, and nurse Gertrude Walters.

* * *

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BEDDING

No. 369. "Care of All-Wool Blankets," a detailed description of the methods of storing, laundering, cleaning and otherwise caring for wool blankets so as to keep them in good condition. Published by Kenwood Mills.

BIRTH CERTIFICATES

No. 425. A pictorial bulletin describing the birth certificates printed by Franklin C. Hollister, Chicago.

BUILDING MATERIAL

No. 436. An eight-page booklet describing and illustrating uses and installations of Acousti-Celotex in hospitals. The manner in which this material acts and methods of its installation are completely described. The Celotex Corporation.

CASTERS

No. 393. A well illustrated descriptive catalog of 68 pages, showing every type of caster, wheel, slide and socket for hospital use, covering the entire Bassick line. The Bassick Company.

CLEANING MATERIALS, SUPPLIES

No. 460. Descriptive literature on the new Standard wall washing unit. Complete instructions for the use of the unit are included. Standard Engineering Company.

No. 376. "Wyandotte Products for Hospitals and Institutions" explains how all cleaning in the hospital and institution can be done, and how every rule of thorough, safe and economical cleaning can be easily followed. The J. B. Ford Co., Wyandotte, Mich.

No. 441. "Sanitation Products for the Hospital." A complete catalogue of Surgical and Baby Soaps and their dispensers, Baby Oil, Disinfectants, Floor Finishes, Floor Waxes, Furniture Polish, and other Hospital and Institutional supplies. The Huntington Laboratories.

No. 392. "Maintenance Cleaning Illustrated." This booklet covers the entire field of maintenance cleaning. J. B. Ford Co.

No. 456. "Autosan." Descriptive pamphlets giving the details of construction and operation of the new Colt Autosan Dishwashing Machines, Models R-16 and 90. Illustrated. Colt's Patent Fire Arms Mfg. Co.

COTTON, GAUZE, ADHESIVE

No. 459. "Hospital Service Book and Catalog No. 3," issued by Johnson & Johnson, contains editorial material about surgical dressings, sutures, etc.

DRESSINGS

No. 444. A series of brochures, describing the following Curity products: Layettecloth diapers, for hospitals, Lisco and Dressing Rolls, Selvage Gauze, Bandages, Cotton Balls and Adhesives. Published by the Lewis Manufacturing Company.

FLOOR MACHINES

No. 445. "Floor Reconditioning." Descriptive material concerning the full line of floor maintenance machinery manufactured by the Lincoln-Schlueter Company. Sanding, Steel-Wool Cleaning, Polishing and Scrubbing Machinery is detailed and illustrated in this new catalogue.

FOOD EQUIPMENT

No. 252. "Scientific Hospital Meal Distribution." Swartzbaugh Manufacturing Company.

No. 453. "Feeding for Health." 20 pages of illustrated information on the achievement of higher standards of food service at lost cost. A score of actual photographs and architects' plans of Pick kitchen installations in modern hospitals are included. Bedside Service, Cost of Operation, Space Allotments, Sanitation, Personnel Dining Rooms and Planning New Hospital Kitchens comprise but a few of the many subjects covered. Albert Pick Co., Inc.

FOOD PRODUCTS

No. 446. "Wheat-Free Egg-Free Milk-Free Products." A fifteen-page booklet of recipes for use in the preparation of meals where an allergy diet is indicated. Published by the Chicago Dietetic Supply House, Inc.

FURNITURE

No. 461. Two descriptive folders covering the Angle line of institutional furniture is available for distribution. James L. Angle Company.

HOSPITAL FABRICS

No. 418. A descriptive folder covering "Horco Hospital Silk," and illustrating the many varieties of silk available, their particular uses and advantages. Samples of silk are included in the folder. Mann Sales Company.

INFANT IDENTIFICATION

No. 390. "Deknatel Name-On-Beads," a pamphlet describing the advantages and uses of this system of infant identification. J. A. Deknatel & Son, Inc.

LABORATORY TECHNIQUE

No. 428. "Vitamin C Titration with Dichlor-phenolindophenol—A Method for the Diagnosis of Prescorbutic Conditions." Written in non-technical language, this pamphlet clearly explains the technique its title indicates. A bibliography of literature on this subject is also contained in the booklet. Hoffmann-La Roche, Inc.

LIGHTS

No. 404. Modern Surgical Illumination. A new pamphlet describing recent and important developments in surgical illumination, prepared by the Wilmot Castle Company.

MATERIA MEDICA PAMPHLETS

No. 429. "Vitamin C—Cevitamic Acid, Synthetic." Nature, chemical characteristics, indications for administration, diagnosis of vitamin C deficiency, and the employment of the synthetic in a number of other conditions is discussed interestingly in this pamphlet. Hoffmann-La Roche, Inc.

No. 437. "Vitamin C Titration with Dichlor-Phenol-Indo-Phenol." A six page explanatory pamphlet on Vitamin C titration. Hoffmann-La Roche, Inc.

MATTING

No. 424. "Why Matting?" a four page folder issued by American Mat Corporation, describing the advantages of rubber matting for use in building lobbies.

MISCELLANEOUS

No. 394. "Polar Water Stills." This catalog goes into the art of water purification, the needs and how to accomplish it, and gives more complete data than has ever been comprehended in a water still catalog. U. S. Bottlers Machinery Co.

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No. 422. "Program Sound System." A descriptive, illustrated twelve-page booklet, explaining the application of the Western Electric Company's sound distribution system.

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No. 412. "Alphabetical Indexing," describing the alphabetical disease and operation indexes; also other essential indexes as statistics cards, patients', physicians', x-ray and laboratory. Physicians' Record Co.

No. 413. "Standardized Hospital Record Forms." Approved forms for professional service, administrative, accounting and all other departments. Physicians' Record Co.

No. 458. "Case Studies," a booklet by an authority on medical records which tells what constitutes a good case history and describes its use and value. Physicians' Record Co.

SOLUTIONS

No. 403. "Parenteral Administration of Fluids," an evaluation of the properties and advantages of Intravenous Solutions in Filtrair Dispensers. In booklet form, this treatise covers these highly important considerations: Blood Volume, Its Significance, Choice of Solutions, Physical Factors, Classification of Indications, Incertitude of Protoclysis, Advantages of Subcutaneous and Intravenous Administration, Technic and Methods of Parenteral Administration, etc. Published by Hospital Liquids, Inc.

No. 450. "The Use and Care of the Filtrair Dispensing Set." A 20-page handbook, profusely illustrated with demonstrative photographs, on Filtrair equipment for intravenous solution injections. The contents include: Sterilization of the Filtrair Dispensing Cap, Opening the Bottle, Attaching the Dispensing Cap, Setting Up the Apparatus, Administering the Solution, Disassembling the Apparatus, and an explanation of the mechanical principles of the Dispensing Cap. Published by Hospital Liquids, Inc.

STERILIZING CONTROLS

No. 451. "The Modern Method of Controlling Sterilization." A descriptive and informative pamphlet which explains the Diack Control and indicates precautions for its proper use. Included are many interesting facts concerning the characteristics and correct operation of small and large autoclaves, and the use of drum and other types of sterilizing containers. A. W. Diack.

STERILIZERS

No. 440. "Relating to the Selection, Arrangement and Installation of Sterilizers." A twenty-four page booklet containing 38 drawings and plans of various types of sterilizer, urinal, autoclave, and condenser units, as well as floor plans of typical installations. American Sterilizer Company.

No. 439. "Suggestions for Sterilization of Water." Twelve practical suggestions, illustrated with descriptive drawings, for the proper sterilization of water and the care of the apparatus. Wilmot Castle Company.

No. 438. "Castle Manual of Correct Sterilization." A booklet outlining a working technique for safe sterilization, practical for physicians, dentists and surgeons, for use in the office and clinic. This manual also includes suggestions for the proper care of sterilizers. Wilmot Castle Company.

SUTURES AND LIGATURES

No. 407. A series of brochures describing the following Curity products: Dermal and Tension Sutures, Gastro-Intestinal Sutures. Also a series of five booklets entitled: "Plain and Chromic Catgut," "The Advance in Absorption Control," "Sterilization and Bacteriological Control." Published by the Lewis Manufacturing Company.

No. 447. A 64-page book, entitled "A Textbook on Sutures," containing the historical and manufacturing background of Curity sutures, as well as full details of their inspection, the operation-room preparation of catgut, the selection of catgut for sutures and ligatures, and explanatory chapters on absorbable and non-absorbable sutures. This textbook, profusely illustrated, was written by Paul F. Ziegler, Director of Research of the Curity Suture Laboratory. Published by the Lewis Manufacturing Company.

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369	456	418	422	439
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1. To elevate the standards of hospital practice.

2. To help in bringing good hospital service within the reach of every man, woman and child.

3. To help physicians, nurses, social workers, dietitians and others having to do with the care of the sick and injured.

4. To assist trustees of hospitals in better understanding their duties, responsibilities and relations.

5. To stimulate the better training of hospital superintendents.

6. To promote the education of the public regarding hospitals.

SAFE MOTHERHOOD

» » "The mother who dies in childbirth, needlessly . . . each contributes to the breaking up of the family, to social and economic loss. All such deaths are examples of the preventive possibilities of public health. . . ."—Thomas Perrin, Jr., M.D., Surgeon General, United States.

Notwithstanding the dire prophecies about the collapse of the American family, it is still the center of the national life and the mother is the center about which the family is grouped. Yet the latest available statistics of the United States Department of Public Health (1924) show a loss in childbirth of 15,000 mothers. The by-product of the motherless families thus created is found in nearly all our social problems, crime delinquency, disease and others. Equally important but less tangible is the loss of those surviving children who are deprived of a mother's love and influence; who are robbed of that indefinable something which brings out the highest and best qualities in the child.

If this were an unavoidable loss it would be bad enough, but experience and statistics both show that a large percentage of this loss is absolutely unnecessary. In New York City, for instance, the Lobenstine Clinic of the Maternity Center Association has just completed its first 1,000 confinements in the homes of patients by carefully supervised midwives with only one maternal death. This record occurred in a city in which the general maternal mortality is nearly five times higher and demonstrates the possibility of an enormous decrease in the maternal death rate.

What is Good Care? The modern practice of obstetrics has established a very definite criterion of good care which has been well stated by the Maternity Center of New York.

1. A complete examination by a competent physician early in pregnancy.
2. A dental examination early in pregnancy and provision of the care needed.
3. Medical and nursing supervision, care and instruction throughout pregnancy.
8. Arrangement for health supervision of the baby and for further care of the mother if needed.
5. An asceptic delivery under the supervision of a competent physician, with skilled assistance.
6. Medical and nursing supervision, care and instruction after delivery, until the mother is able to resume her usual activities and to carry the additional responsibility of a new baby.
7. Post sartum examination, one, two and three months after delivery with follow-up treatment if indicated.
8. Arrangement for the health supervision of the baby and for the further care of the mother if needed.

Why Are Mothers Not Receiving Good Care?—Careful study of maternal deaths and the conditions under which they occurred has furnished the answer:

1. Ignorance.—A large percentage of maternal deaths is due to two factors of ignorance. Prospective mothers do not realize that they should be carefully watched during pregnancy and, if they do feel the need of some medical service, some do not know where it may be secured.
2. Lack of provision for free care in the community. The patient who can pay for her care can and should consult her regular physician, but in many communities there is no systematized provision for care of the indigent.
3. Negligence.—Many pregnant women, like those suffering from pathological conditions in general, do not consult a physician as early as actual symptoms may indicate.
4. False pride.—This is a sin of the moderate wage earner who feels that she must economize and so cannot consult a physician whom she is expected to pay, and who will not force herself to accept the free service which may be offered by the community.

What is to Be Done? The answer to this question is a corollary to what has already been stated.

1. Create a demand. The late Dr. Whitridge Williams, of Johns Hopkins University, once said,

"When the women of America realize the value and need of maternity care, they will demand it. Then, and only then, will they get it." The channels through which the demand may be created are already available and need only be made use of—newspapers, magazines, radio, lectures in churches and other similar organizations and other regular means of publicity. By these means the public must be brought to understand that motherhood, while it is a natural event in the life of a woman, may not be normal, that many abnormalities and complications may arise that demand expert medical care. The public must realize that death or ill health may be the penalty for negligence. Expectant mothers and fathers should know what care they may expect from their doctor, their nurse and their hospital. When these ideas are widespread, then the demand will be created.

2. Provide the care thus demanded. For those who can pay for their care, the private physician is available in every community. Almost without exception he understands the necessity for maternal care and is both willing and able to furnish it.

For the indigent or for those who are struggling for an existence the problem is not so easily solved. In the larger communities, maternity centers are usually organized, but in some large cities and in a great number of the smaller ones as well as in rural communities such facilities are woefully lacking. In every community, regardless of its size, provision should be made whereby the person struggling along on a moderate income may get care at a low rate and the indigent may receive free service. The local hospital is the logical place in which to establish free clinics; the part pay patient may be cared for in the physician's office or at the clinic, depending entirely on the community.

Responsibility. The responsibility for saving mothers is twofold. Fathers and mothers must be made to realize the the necessity for adequate maternal care and the community must provide it. The responsibility of the community is not only a moral one; it is also economic. It costs the community less to save the mother than it does to bury her, to care for the motherless child and to combat the child delinquency or other result of the loss of the mother in the home.

HOSPITAL FINANCES

» » Elsewhere in this issue is an article by the editor in which he calls attention to certain aspects of the financial situation in hospitals. The recent strikes and threats of labor trouble suggest that the hospital administrator give the reciprocal problems of operating costs and revenue serious consideration and thereby forestall the threatened danger to effective care of the sick.

In preparing the article, it was felt that no advantage would be gained by any extensive survey, since the root of the problem is the same in every community and slight local variations in figures would only cloud the issue. For this reason a typical hospital was chosen and, in considering the payroll, the employees selected for the analysis give a good cross section of the pay to personnel. The figures are accurate since they were personally secured from the hospital mentioned and from the management of hotels and business in the same community.

Costs are inevitably rising, income from voluntary sources is unreliable and good business management points to an increase in rates and stabilization of income. Stabilization is in reality the more important of the two. The hospital must be assured of cost plus a reasonable profit from patients in the higher income categories, cost for adequate care from the moderate wage earner and cost from the community for the indigent.

The conclusions are those of the editor and no suggested remedy is theoretical. All have been observed in successful operation.

Announcing---

HOSPITAL MANAGEMENT announces the appointment of Thomas R. Ponton, B.A., M.D., as editor.

To a large part of the hospital field, Doctor Ponton needs no introduction. For the past several years, he has travelled throughout the United States and Canada as a consultant in hospital organization and as field representative of the American College of Surgeons. In this capacity, he visited all types of hospitals and acquired a most extensive knowledge of hospital practices and conditions in every state and province in North America. He brings to the readers of HOSPITAL MANAGEMENT the benefit of this specialized experience and training, a wealth of information that is unique in the field.

Prior to his affiliation with the American College of Surgeons, Doctor Ponton was, for five and one-half years, with the Vancouver General Hospital, first as Director of Medical Records and, subsequently, as assistant Administrator. During the War, he was a member of the Canadian Army Medical Corps for two and one-half years. His "Alphabetical Nomenclature of Diseases," originally published in 1927, has since been revised three times and is now in use in over 1,500 hospitals in the United States and Canada.

It is with considerable satisfaction that the publishers welcome Doctor Ponton to the editorship of HOSPITAL MANAGEMENT. We feel that, after four years, a worthy successor to the beloved Mathew Foley has been found, and that the change will be reflected in a more constructive, informative and authoritative editorial policy and content. With this issue, the first under Doctor Ponton's guidance, HOSPITAL MANAGEMENT steps into a further enlarged sphere of usefulness to the hospital world.

The Financial Situation in the Hospital

By T. R. PONTON, B.A., M.D.
Editor, Hospital Management

» » » THE PRESENT PERIOD of changing conditions and financial readjustment is one that is bringing an increasing number of problems to the hospital and its administrator. Costs are constantly rising and, in most instances, the advance is beyond the control of the administrator. Revenue with which to meet the added costs has not shown a comparable increase, with the result that it is becoming more and more difficult to meet the expenditure. Yet the sick must be cared for and the quality of service cannot be reduced. The problem resolves itself into an analysis of the financial situation.

Fixed Financial Obligations

All hospitals have certain fixed financial obligations some of which may be relegated to the capital account while others are provided for out of operating revenue. Among the capital items are mortgages and bonded indebtedness and interest on these items. This is usually charged against the corporation as a whole, and, while there is some debate as to whether the nonprofit hospital is justified in applying operating revenue to this account, it is certain that few are able to accumulate any operating surplus available for the purpose. Taxes and insurance are commonly paid out of operating revenue. The administrator of the hospital may be necessarily concerned over the capital account but it is a secondary worry and this article will be limited to a discussion of some features of the operating account, as they affect costs and revenue.

Operating costs may be roughly divided into two large groups, the payroll and the purchase of supplies, including in this latter the replacement of equipment.

Pay to Employees

Those employed in hospital service have always felt that their compensation was twofold. First, of course, is the pay check which is a necessity, but there is also a feeling of satisfaction at having a part in the care of the sick. Partly due to this second element in the compensation and influenced also by the fact that the hospital is endeavoring to give service at as low a rate as possible, the pay received by employees of the hospital is, in some instances, out of proportion to that received in comparable employment in business and industry. While the humanitarian attitude is laudable and should never be eliminated, care must be exercised to see that the practical compensation of the pay check is not too far out of balance. Hospital employees, like all others, require money in order that they may have the necessities of life.

During the depression the personnel, voluntarily in most instances, took large cuts in pay, in many cases far greater than the reduction in other employment. Some cases are known in which they went so far as to actually forego all regular payrolls for long periods of time agreeing to accept any surplus that might remain after current trade accounts had been met. The reason for this latter arrangement was twofold. The employee recognized that he was better off receiving a small wage than none at all but the great incentive was a recognition of the fact that the hospital must carry on and that the only way in which this could be accomplished was by great sacrifice on the part of the employees.

The depression is past or is rapidly passing; costs of living are steadily increasing; rates of pay in all industries are constantly being revised upward. The hospital employee is forced to meet the greater cost of living but in many instances the revenue of the hospital has not been sufficient to warrant an increase in the payroll comparable to that which has been effected in other business. The result is inevitable; the employee is not satisfied. In many cases he is seeking more remunerative employment elsewhere; in others he is carrying on for many reasons which need not be analyzed beyond stating the fact that one of the greatest is his feeling of responsibility toward the sick. But a feeling of responsibility will not pay rent, meet the grocer's bill and educate the children. It is inevitable that the rate of pay must increase in those categories in which it still shows too great a variance from outside standards. This increase will be initiated from one of two sources. Either the employee will force the issue, or the administration will take the initiative in making increases where they are necessary.

This naturally brings up the question of organization in labor, a subject which is too broad to receive intelligent discussion at this time and for this reason the writer does not wish to be interpreted as expressing himself either for or against such organization. It is sufficient to call attention to the fact that unionization has already entered the hospital field as evidenced by much unrest and one or two strikes which have been reported. Regardless of which side one might wish to take, there is an undisputed fact that

must be kept constantly in mind. The hospital is essentially an humanitarian institution, necessary to the community for the care of the sick, and must continue to operate in spite of all difficulties and differences of opinion. Demands of employees must be reasonable and must be made with thought as to what it is humanly possible for the administration to accomplish. The administration, on its part, must be equally amenable to reason. A spirit of compromise must be evidenced on both sides in any question that may arise. Public sentiment will not tolerate any action which could jeopardize the lives of those who must entrust their safety to the hospital. All those concerned with the proper functioning of the institution are responsible and the individual or organization, whether in the administration or personnel, which in any way causes interference with the proper functioning of the hospital, will be condemned by the public in general.

What Is Meant by the Rate of Pay?

Before attempting to make any analysis of rates of pay it is necessary to determine what is meant by the expression. The rate of pay is not merely the amount of the regular pay check or pay envelope. For various reasons it is necessary or advisable to furnish part or full maintenance to employees of the hospital, which is just as much a part of the compensation as the pay check. Yet it is rarely that this is specifically taken into consideration. The employee receives a stated amount per month plus specified or unspecified maintenance privileges which have a definite value in cash, but which is not usually stated in the payroll. The result is inevitable. The employee disregards the value of maintenance and comes to consider his pay check as his only compensation, thereby gaining an impression that his rate of pay is less than it is in actual fact and he is consequently more dissatisfied with his lot than is justifiable. On the part of the administration an equally unwarranted paternal attitude often develops. The employee is regarded as receiving his pay check and in addition he is given (not earns) partial or complete maintenance.

The payroll should show the actual cash paid the employee plus the value of any maintenance received, appraised at the price the individual would pay for it if he went outside and purchased the same item. This, of course, brings up the question of determining values of housing, laundry, hospital care, meals and other items, and the most difficult to appraise is the value of food received. In most instances the employee is required to take meals when on duty and the hospital finds that it is economy to serve the same meal in all dining rooms. The employee in the lower wage categories is thereby served a meal which costs more than he would pay if he were free to bring a lunch or go elsewhere. In common justice, if the employee is required to take certain meals in the hospital, he should be charged, not the cost of the meal, but at the rate he would pay if he were able to get it at his own selection. If, however, he elects of his own free will to have any of his meals in the hospital, they should be charged at cost. The value of other items should be determined and charged in an equally equitable manner.

Comparison of Rates of Pay

For the purpose of the present discussion a national survey would serve no useful purpose nor is it necessary to analyze the entire payroll. Chicago will be taken as a typical city. The rate of pay is in some instances higher, in others lower, than elsewhere, but on the whole, it is about an average. In Chicago an average hospital has been selected, one of slightly over 200-bed capacity, well managed and caring for both paying and free patients. The rates of pay to employees will be compared with those of comparable business in the city. Certain positions will be selected to secure a cross section of the different classes of employee, and for the purpose of calling attention to the principle under discussion. Five test cases will be sufficient to illustrate the principle, viz., the administrator, clerical help, nursing (general duty), maid service and male labor.

The Administrator.—The administrator of the hospital selected is responsible for the protection and maintenance of property and equipment valued at $2,000,000. He has organized and controls 270 employees (including under-graduate nurses), the entire responsibility involving a monthly turnover of $35,000. In addition to these, which may be considered his executive duties, it must not be forgotten that the hospital of the present day is responsible for providing that the patient receives proper care and, with his numerous other duties, the superintendent must be certain that a medical organization is maintained adequate to care for 190 patients per day. This man, who has had many years' experience in hospital administration and is placed among the first 30 in national reputation, receives a salary of $6,000 per year, with no maintenance. Is there any other business or indus-

All operating costs in the hospital are steadily rising. The business management is generally good and no further economies can be practiced without lowering standards. Income from earnings must be increased and stabilized. Hospital rates are generally below the cost of the service rendered and must be increased if the hospital is to continue to function efficiently.

try which would expect an executive of this caliber to successfully carry a comparable load of responsibility for such a meager salary? Had he entered any other business at the time he commenced his career as a hospital administrator, he would be receiving at least twice his present compensation.

Clerical Staff.—The secretary to the superintendent is considered a typical example of this class of employee and a fair comparison can be made with women in similar positions outside the hospital. This woman, who must be a good secretary and stenographer, receives $100 per month plus a noon meal (dinner) for six days per week, which is valued at 35 cents per meal, or $9.93 per month, a total compensation of $109.93. In Chicago a good stenographer can be had at a salary from $75.00 per month up. A highly skilled stenographer is paid approximately $100 per month. A very highly trained secretary receives $150 or more. The secretary in the hospital under discussion is receiving approximately the same compensation that she could earn in outside employment.

General Duty Nurses.—Under this heading are considered those graduate nurses employed by the hospital for general nursing care. The following is their compensation:

	Per month
Salary*	$ 60.00
Three meals per day ($1.00 per day)	30.41
Laundry (estimated)	7.00
Room**	20.00
Total	$117.41

There is no comparable occupation in business, but it will be noted that these women, who have had three years of training in their profession, plus experience since graduation, are receiving no more than the skilled secretary in business.

Floor Maids. A floor maid is selected in the female labor class to be compared with a similar maid in a good apartment hotel. In the hospital the maid is paid $50.00 per month plus 3 meals per day for 6 days per week, valued at $22.80 per month (breakfast .15, noon dinner .35, supper .25), a total of $72.80 per month. The maid in a comparable apartment hotel receives $47.50 per month with no maintenance. In the hotel, however, there are numerous tips which are a substantial part of the compensation and which are considered by the maid when entering the employment; in the hospital there are no such tips. Both are furnished with uniforms. There is no means of evaluating the tips in the hotel, but the total compensation to the hospital maid would appear to be at least equal to that received in the hotel.

Male Cleaners.—These men are comparable to the cleaners in an apartment hotel. In the hospital they receive $65 per month plus three meals per day, valued at $22.80 per month, a total compensation of $87.80 per month. In the apartment hotel the same class of help receives $75.00 per month, with no maintenance and there is little or no opportunity for receiving tips. The cleaner in the hospital receives, therefore, greater compensation than the same employee in the hotel.

Engineers, carpenters, painters and similar skilled mechanics are not considered because they receive the same scale of pay as in industry. Some other personnel, such as orderlies and ward attendants, are also omitted because there is no comparable employment in business or industry.

It is concluded, from the test cases discussed, that the compensation in the professional classes in hospitals is low, but that, in the clerical and labor categories, it equals or exceeds that at present paid in outside employment. A revision of the payroll is indicated and this will involve a total increase. This is, however, a comparatively small part of the problem. The administration will find it necessary to carry the investigation into the cost of supplies and the possible sources of income.

Cost of Supplies

All reliable statements from governmental and other authoritative sources show a general increase in the cost of commodities and it would serve no useful purpose to elaborate on these at this time. A statement from the Grinsted Hotel Food Price Index is sufficient to illustrate the point. That authority states that, evaluating the weighted average food price in January, 1934, at 100, the price in March, 1936, was 118.69, in March, 1937, 123.89. There is undoubtedly a definite increase in cost of supplies which, when added to the increased payroll, results in a substantial rise in operating costs.

Notwithstanding unsupported statements to the contrary, the writer, after personal observation of hospitals in all parts of the United States and Canada, is of the opinion that the business management will, in nearly all instances, compare favorably with that in other business and industry. During the years of the depression careful management was necessary to continued existence and all possible economies were carefully studied. As a result every transaction was systematized and brought under the strictest control. The resulting business efficiency and prevention of waste is still in evidence and further saving is impossible, except at a sacrifice of service.

Sources of Income

Since expenditure is showing an unavoidable rise and must be met, it follows that the administrator must devote a great deal of thought to means of augmenting and stabilizing the revenue. Income is derived from endowments, from contributions and charities, from grants by governmental bodies and from earnings.

Income from Endowments. Few of the thousands of hospitals in the United States and Canada have any endowment and there are only one or two which have sufficient to take care of the deficit created by free and part pay work. During recent years income from endowments has markedly decreased and, while it is again on the upward trend, it cannot be generally considered as an appreciable source of support.

*One hospital in the city has raised the rate of pay to $70.00 and has budgeted for $75.00 for 1938.

**Two persons in one room in the hospital, valued at the cost for three in an equally comfortable apartment with complete hotel service.

Income from Contributions and Charities. In a large percentage of communities funds for the care of those who are unable to pay are provided wholly or in part from community chests and similar sources. In normal times this is a reasonably satisfactory method and it has the advantage that, after the drive, the hospital knows the amount of money that will be available. But revenue from this source, like that from endowment, has been greatly decreased at a time when it was most needed, and it, too, has not shown an increase comparable with the advance in costs. Dependence on such charitable contributions has two great disadvantages. The hospital must take what those in control of the fund may allot, and, while the contribution is always welcomed, the administrator has no control over the source of supply. It may be far below the amount of service which must be rendered in return for the contribution. From the point of view of the general public also it is unsatisfactory as a major means of caring for the indigent sick. The load is unequally distributed in the community, those who are accessible and willing contributing practically all the fund while others, who are perhaps better able to support charity, give little or nothing.

Income from fixed grants by governmental bodies. These are fixed sums of money allocated by city, county or other governmental bodies for the care of the sick. In some States and cities grants are available only for publicly owned hospitals; in others privately owned institutions may participate. The source of the grant is taxation, so the load is distributed over the community as equitably as the systems of taxation can provide. From the point of view of the hospital they are satisfactory in that a fixed amount is available, but this amount is determined by an estimate of the amount of free work to be done during a stated period subsequent to the estimate. If the estimate is sufficiently high the hospital has amply provided for its needs, but if it is too low the institution has contracted to do the work at the expense of a deficit which must be met from some other source or by again approaching the governmental body and begging for more money.

Income from Earnings. This is the major income of the hospital and if properly collected is entirely under control of the administration. If the hospital gives service at a reasonable rate and if the community is not overhospitalized, the institution can earn sufficient to care for all its needs provided rates are sufficiently high and payment for all classes of patients is assured. This statement needs elaboration.

While rates must be reasonable, they must be sufficiently high to cover costs and collection must be assured. This policy is not only justifiable under advancing costs of hospitalization, but it is imperative if the hospital is to continue to function as effectively as the community has a right to demand. Too long have hospitals meekly submitted to unjust attacks concerning the cost of management and assumed a defensive attitude. They should take the offensive; they should show that rates are lower than are warranted by the service demanded and rendered; they should not be required to meet the deficit resulting from service rendered below costs, by the many subterfuges at present practiced; they should demand a reasonable profit from patients in the higher income categories and an assurance of compensation at cost for all other. These matters should be brought to the attention of the public by all legitimate means of publicity.

Patients in the higher income category, occupying private rooms. Patients in this category are able to pay for the service they receive. If they are not willing, they should be required to take less expensive accommodation and should not receive the superservice furnished to those who want it and are willing to pay for it. People in this income class, when they go to an hotel, pay from $4.00 up for a room with only its maintenance. Meals are not included and any services beyond mere housing is either an additional charge or is paid for in tips. In the hospital, in a comparable room, the rates are from $4.50 up, including meals in bed, expert nursing service and all the other care necessary to treatment of illness. In addition expensive operating rooms, X-ray departments, laboratories and similar adjunct facilities must be maintained for these and other patients, whether they are used or not. The minimum rate charged today for the private room is below cost and should be raised. Few, if any, hospitals in the United States can supply private room service at $4.50 per day, unless they plan on charging for an unjustifiable number of extras. The basic rate for such accommodation and service should be sufficiently high to cover the cost of regular service; extras should be limited to those items which are part of an unusual service to the individual and collection should be strictly enforced. Moreover, the hospital is justified in taking a moderate profit to cover unavoidable bad debts and other items which cannot be foreseen.

There are one or two notable exceptions to strict collection for private room service. The first has regard to the condition of the sick. At times a mental patient must be hospitalized and cannot be accommodated with others; a patient may be suffering from a communicable disease; some patients are so seriously ill as to require the quiet of a private room if their treatment is to be successful. These are administrative and humanitarian problems which must be solved without any consideration of the financial aspect. The patient must come first; he must be given the accommodation demanded for his safety and that of others, regardless of his ability to pay.

There is another exception to the rule applying to strict collection methods—that of the person who has, through no fault of his own, been reduced from affluence. The mental suffering entailed in forcing such a patient to accept ward accommodation is akin to the motive necessitating an exception in serious physical illness. The superintendent must have leeway to exercise judgment in such matters and from these patients bad debts will certainly accumulate.

Patients in the Moderate Wage Earning Class. The moderate wage earner constitutes a vast majority of the population and is one of the greatest problems

in furnishing medical and hospital service. He is usually a very reasonable human being. He knows that he can afford only the care necessary for the treatment of his illness and does not demand superservice. He is willing and able to pay for this and the hospital should help him in his misfortune by furnishing adequate service at cost. He is accustomed to pay for everything beyond ordinary living expense on the budget or installment plan and the hospital should allow him this financial accommodation. This may be arranged by payment after the service is rendered or by prepayment as exemplified in "Group Hospitalization."

Payment after service is rendered is undesirable since it mortgages the future of the wage earner, often to the extent of being a distinct handicap. But, if the patient is not in the indigent class and has not made provision for illness it is a necessary evil. It may be said to the credit of patients in this category that, usually they live up to their obligations. HOSPITAL MANAGEMENT expects to publish, in the near future, an article written by a superintendent who has successfully used such a system.

The better system is the prepayment plan as illustrated by "Group Hospitalization." This method has been receiving much attention in recent years and many plans are in effect. Since it is entirely a new idea with no experience to guide it in the beginning, it has been based almost entirely on theory and consequently many mistakes have been made. The question is too extensive to allow discussion in the present article, but the whole subject is being carefully studied by the American Hospital Association, under the able direction of C. Rufus Rorem, and no doubt the defects of present systems will be found and eliminated.

Care of the Indigent

The indigent patient must be cared for and this is universally recognized as a community responsibility. Apart from the humanitarian obligation, it has been shown that neglect to provide for his care is economically an unsound policy. In many cases he must be hospitalized, but he is unable to pay for his care. The deficit thus created may be partially met by income from endowment, by profits from paying patients, by contributions from Community Chests and other charities and by payments from governmental sources. Usually there is a remaining deficit which the hospital must carry by paying below standard salaries and by deferred trade accounts. The salaries remain low until some action is forced; trade accounts accumulate until pressure for collection becomes so great that funds must be raised. Then the community, through its governmental sources or by a special drive, furnishes sufficient money to partially or entirely pay the trade debt and re-establish credit, after which the whole deplorable process is repeated.

Care of the indigent, as has been repeatedly stated, is a community problem, the hospital, whether public or privately owned, being only one of the agencies through which it is provided and the community has no right to demand that only hospital furnish such care unless provision is made for meeting the cost. Such funds, whether by subscription or taxation, eventually come from the taxpayer and it is immaterial by which means they are derived except that taxation is more certain to distribute the load equitably.

Philanthropy and charity will not be discouraged by the principle of tax support for the indigent sick. There will always be a legitimate demand for such funds, particularly in rendering necessary assistance to those of the moderate wage earning class who do not wish to be classed as indigent or who are not eligible for such classification. There is also a large number of indigents who will not be accepted as a proper charge against tax funds.

An ideal method of paying for the care of the indigent by taxation is in effect in the State of Michigan and is described in an article in the present issue, "A Workable Program for the Care of Indigent Patients," by Superintendent Ralph M. Hueston.

Conclusions

To summarize the foregoing discussion, the following conclusions may be stated:

Rates of pay to employees are not so far out of balance with those in comparable business and industry as is generally supposed, but adjustments are necessary and the result will be an increased payroll.

Costs of supplies are steadily rising and the administrator has no control over this item of increased expenditure.

The management of hospitals is generally as economical and efficient as in other business and industry and no further economies can be practiced without a sacrifice of standards.

The net result is an increased operating cost which cannot be avoided and must be met by increased revenue.

Income from endowments, as well as from contributions and charities, decreased during the depression and has not increased in the same ratio as the advancing costs.

Grants from governmental sources are usually inadequate to pay for the free service demanded and are often not available for the privately owned institution.

Income from earnings must therefore be increased and stabilized to assure at least a cost rate return for all patients treated.

Private room service should be charged for at cost plus a reasonable profit and, with few exceptions, should be refused to those who are unable or unwilling to pay for it. Collection should be as rigidly enforced as in any other business.

Patients in the moderate wage categories should be given adequate care at cost and should be assisted financially by a prepayment or a postpayment plan.

The care of the indigent in hospitals is a community responsibility and the community must furnish sufficient funds to pay for the services actually rendered. This is best provided through taxation.

The voluntary hospital caring for the indigent patient has as great a claim on the community for support of these patients as has the government-owned hospital. The amount of such support should be on a basis of fair valuation of services rendered.

Business Methods in the Hospital

Discussion by G. A. Friesen, Business Manager, Saskatoon City Hospital, at the sectional meeting of the American College of Surgeons, Edmonton, Canada, March 24 and 25.

1. How far should the hospital management go in enforcing payment of accounts when the patient is admitted as full pay or part pay in:

(a) demanding payment in advance?

No hard and fast rule should be made in demanding payment of hospital accounts in advance. This would depend entirely on the bona fides of the patient. In most cases, the admitting officer can determine the limitations of the patient's financial resources by the time the interview is completed and, in this way, place the patient in a ward suitable to his paying ability. Unless the patient is considered a "gilt-edged" credit risk, it is advisable to demand a deposit weekly in advance when special accommodation is requested. If he cannot pay a deposit immediately, he may be given twenty-four hours' grace, but, if it appears that the matter of payment is uncertain, the collection manager should be advised immediately, in order that a credit report may be obtained to ascertain the paying habits of the patient among the retail trade, earnings, etc. Under some circumstances investigations as to the patient's financial status may be instituted as soon as the doctor makes the reservations.

(b) requiring a guarantor when an account is doubtful?

It is quite an easy matter to insist on a guarantor, should the patient whose financial status is doubtful, occupy a semi-private or private room, as one can quite frankly advise him that, if he demands special accommodation, we can quite rightfully demand our own terms, but, if the patient must be hospitalized and is quite willing to be admitted to a ward, the problem of insisting on a guarantor becomes acute. Of course the hospital is protected, to a certain extent, by the Municipal Act, as each municipality must make due provision for its indigent sick; however, that usually does not cover the patient who is an undesirable credit risk, but not considered indigent according to the Municipal Act. The hospital would be well advised to delay admission of a non-emergent patient who is considered a doubtful credit risk until the account is guaranteed by the municipal body where the patient resides, or insist on the endorsation of his signature by some person of good credit standing, known to the hospital. Investigation of emergent cases obviously must take place after the patient has been admitted.

(c) taking a note or other security for any unpaid balance at the time of discharge?

There can be nothing wrong in insisting on business-like arrangements being carried out if the patient leaves the hospital with an unpaid account. It is most essential, under such circumstances, that suitable security be obtained when anything but a first-class credit rating is available, as it is a known fact that debt adjustments and moratorium legislation have made it most difficult to collect an unsecured account. It is also apparent that a great percentage of our citizens have become so thoroughly inured to the perpetual state of indebtedness that ordinary collection procedures will have no effect whatsoever. The various types of security may range from the simple promissory note to a land mortgage. The promissory note is of no specific value except that the question of liability is settled and the terms of payment are indicated. Chattel mortgages and land security can be quite remunerative. Assignments of debts which are due or accruing due to the patient are very effective. It would be of great assistance to hospitals if legislation were enacted making liability insurance compulsory for motorists, as well as compelling the insurance companies concerned to pay the hospital bill direct, rather than through the claimant.

(d) transferring to lower-priced accommodation or to free ward?

Transferring to cheaper accommodations should be avoided as much as possible, as the patient is always abnormal, either mentally or physically, and the change of environment, particularly after occupying the better type of accommodation, usually tends to upset the patient, which does not add to his welfare or his friendly attitude towards the hospital. It is, therefore, most essential that every precaution be taken by the admitting officer to assign the patient to the ward suitable to his paying ability; however, despite the care that may be taken, there will be some cases that have to be transferred, as it would be folly to permit a patient to assume financial obligations beyond his means.

2. Should hospitals in the same community adopt uniform schedules of charges? Can hospital charges be standardized?

Competition among hospitals, such as cutting rates below the cost of care in order to secure contracts or attract patients, is not in accordance with the Hospital Code of Ethics. (This has been stressed by Dr. MacEachern in "Hospital Organization and Management.") It is, therefore, imperative that the hospitals

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A WORKABLE PROGRAM FOR CARE OF *Indigent Patients*

RALPH M. HUESTON
Superintendent, Hurley Hospital, Flint, Michigan

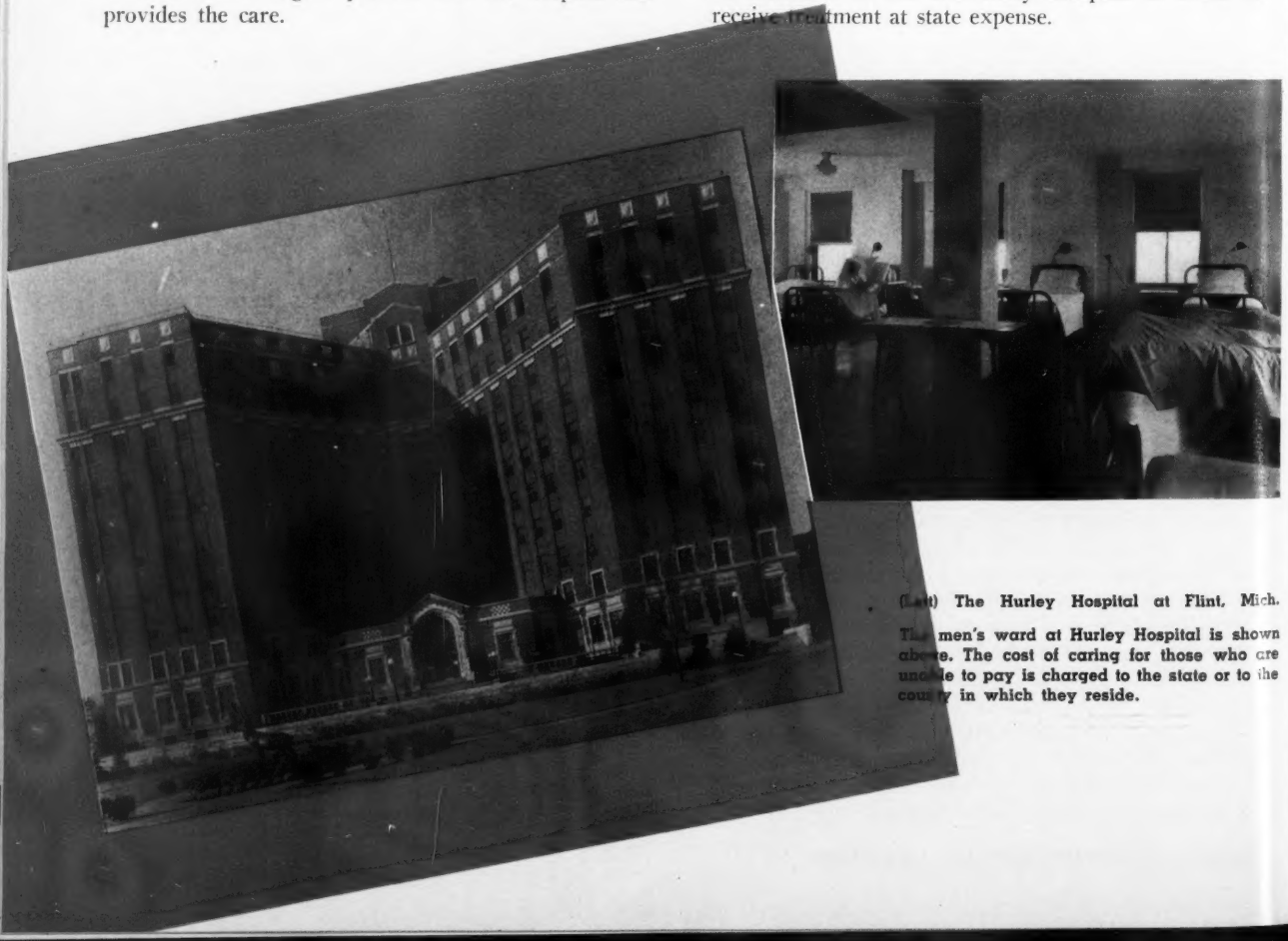
» » » AS A MATTER of general information, Hurley Hospital is a city owned hospital. For all intent and purpose, even though it is city owned and supported by taxation, Hurley Hospital is operated as a voluntary hospital. Accommodations available for patients are private rooms, semi-private roms and wards up to eight beds in size. The rate for wards is $3.00 a day. The rate for semi-private accommodation is $4.00 a day. The rates for private rooms are from $6.00 to $8.50 a day. Since January 1, 1937, the hospital has averaged 427 patients a day.

The hospital maintains no public wards and has no paid staff of physicians for the care of indigent patients. Each patient is a private patient in that each patient is under the care of a private physician. Patients are divided approximately two-fifths private pay patients and three-fifths indigent patients. Each subdivision of the government is responsible for the expense of hospitalizing its own indigents.

Most significant in the program for the care of indigent patients is the splendid cooperation which prevails between the various agencies responsible for the care of these indigent patients and the hospital that provides the care.

The state has made provision for the care of the indigent afflicted or crippled child, but has left the responsibility for the care of the indigent adult to the county or the city, depending on the residence of the patient.

As early as 1881 the Michigan Legislature enacted a law which laid the foundation for the present state program for the hospitalization of afflicted and crippled children. It provided for dependent persons medical and surgical treatment, or either, together with board, lodging, nursing and other proper care free of charge at the State University Hospital. The general assembly of 1897 extended this state policy to apply specifically to minors by requiring all physicians to report to the proper local authorities children who at birth shall be afflicted with any deformity or malady that may be cured by a surgical operation. Such authorities were empowered to transport them with an attendant to the University Hospital in order to receive treatment at state expense.



(Left) The Hurley Hospital at Flint, Mich. The men's ward at Hurley Hospital is shown above. The cost of caring for those who are unable to pay is charged to the state or to the county in which they reside.

At the right is shown the playroom in the children's ward in Hurley Hospital, in which many state-supported crippled children are treated.

In 1915 similar medical care was extended to afflicted adults at county expense in the State University Hospital. Ten years later the power was given to probate courts when the health or condition of the child shall require it, to place the child in a public hospital or in an institution for special care for treatment at county expense. A later statute authorized the same court to refer children to any institution or hospital with which the county board of supervisors may have contracted for service of this kind to be paid from the general county funds.

An act of 1913 provided free treatments at state expense for deformed or afflicted children at the State University Hospital, when assigned there by order of the probate court. Portions of this act were repealed in 1927. It was not until 1933 that a radical change in the crippled children's act was made. The age limit was reduced from 20 to 18 years and courts were authorized to order children into any approved hospital in the state.

It is interesting to note that the commission divided hospitals in two groupings in considering their application for approval. All those previously accredited by the American College of Surgeons were in the first and all others in the second grouping. The first was approved without further investigation. During the first two years and thereafter the hospitals were required to secure a certificate of compliance from the office of the State Fire Marshal. The same procedure was used for the second grouping and in addition there was required the advance approval of the county medical society, a statement signed by the county medical society showing the type of malady which, in its judgment, the hospital was equipped to efficiently and properly treat.

The state has a fixed program for paying the physician for the care of patients that come within these acts.

With the increased burden of county and city indigent patients, the agencies responsible for these patients applied to the Board of the hospital for special rates. The hospital is dependent upon receipts from patients' accounts paid either by the patient, or by some agency for the patient, for the greater amount of the funds necessary to pay operating expenses. The balance of the fund comes to the hospital in the form of an allocation from city taxes. The basis for this allocation is the difference between the operating expenses and actual cash receipts from all sources.

The hospital being city owned can receive allocation of tax money only from city taxes. As funds for county welfare patients are provided from county taxes and funds for city welfare patients are provided from city taxes, it was decided that each department should provide the funds for hospitalization of indigent patients from its department. The basis finally decided on was to charge the respective agencies according to the service actually provided to patients. This policy assured the agencies they were paying only for such service as they should pay for.

It also provided satisfactory fee schedules to the hospital for the care of patients from these agencies. The program as finally adopted, and now in effect, is that, with the exception of special rates for X-ray, the hospital is paid ward rates plus extras for the care of county and city indigent patients and is paid a flat rate for state cases. The mechanics for handling state, county and city indigent patients are so simplified that little difficulty is experienced in carrying out the necessary detail.

Any regularly licensed physician may order an afflicted or crippled indigent child into the hospital. The doctor then makes out what are called the "Physician's Papers." The parents of the patient then apply for aid to the welfare department either of the city or the county, depending upon the patient's residence. When aid is provided the parents are required to sign an agreement to repay the state if able.

The city or county agency refers the case to the "Medical Filter Committee." This committee makes the necessary investigation and either approves or disapproves the application. If approved, court papers are made out and forwarded to the hospital. The hospital presents these papers to the probate court. The probate court makes out regular "Commitment Papers" in triplicate. One copy goes to the afflicted children's committee of the state and two copies to the hospital. On discharge of the patient from the hospital, the hospital forwards same with billing to the auditor general. As provided by the Michigan Legislature, the state pays out of state taxes for the care of minors coming under the Afflicted and Crippled Children's Acts.

The only exception the state makes is in cases of venereal diseases. Such cases follow the same routine as other cases. The state pays the original account to the hospital but charges the account back to the county.

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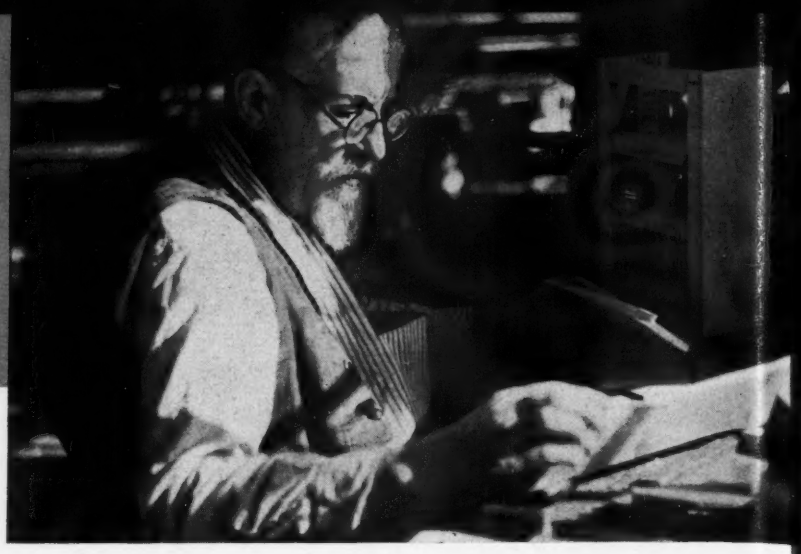


Care of the Chronic Indigent at We

By MAXWELL LEWIS
Superintendent, Home for Dependents, Welfare Island, N. Y.

» » » THE NEW YORK CITY HOME for Dependents, a municipal institution of the Department of Hospitals, houses a daily average of seventeen hundred guests—about one thousand men and seven hundred women. Any one month discloses approximately one hundred admissions and about the same number of discharges. Those who are admitted are mostly in the age groups from sixty to eighty, the average age being close to sixty-five. They come from any one of five sources—from the Municipal Lodging House of the Department of Public Welfare, from the Magistrates' Courts for a period not exceeding six months, from the Department of Hospitals, from private agencies and from our own Social Service Department. Seventy-five various individual agencies contributed last year to the admissions. They represent the major religions—Catholic, Protestant, Hebrew, Mohammedan and Greek Orthodox.

The condition of those in the Home and those being admitted indicates definitely some form of physical ailment in at least 85 per cent. A study of their social histories provides the information that seventy-eight various skilled and unskilled past occupations are represented. There are actors, bakers, bartenders, cabinet makers, carpenters, engineers, hatters, ironworkers, longshoremen, machinists, plumbers, seamen, sculptors, stonecutters, watchmakers, journalists, opticians, an undertaker and a grave digger.

These are the seventeen hundred human, living souls we must properly care for, house, feed, clothe, provide medical and nursing care, and for whom we must carry out the provisions of the Public Welfare Law. Section 93, paragraph (G) which specifically states that we must "as far as practicable provide suitable employment for any inmate whom the attending physician pronounces able to work, assigning such inmates to such labor in connection with the farm and garden, or the care and upkeep of the buildings and other suitable tasks in the public home as they be deemed capable of performing, and providing occupational or other diversions as may be for the best interests of the inmates."

The procedure which is followed in the New York City Home for Dependents in order to comply with the provisions of the law is:

An applicant for admission to the City Home is met on his arrival by the Admitting Physician and is given a thorough physical examination to determine his or her admissibility, and all findings, physical and history, are thereupon entered on a medical chart. At this medical examination the examining physician indicates if the applicant is admissible and if so, further classifies the individual as to work ability—heavy, light, sedentary, or none at all—and the number of hours daily the new inmate could safely work in accordance with the classification. Furthermore, he orders the usual routine laboratory tests for the new admissions. A copy of the admission findings is given to the Social Service Department.

Then follows the usual preliminaries of bathing, clothing, assigning to ward or bed. The guest is then permitted to acclimate himself for a few days in order to become accustomed to his surroundings. He is then given a social service interview for the purpose of ascertaining completely his own and family social background and history. These findings are made part of the guest's medical chart. Another day or two are permitted to pass so that the individual is not confused by questioning and again he is given an interview by the worker in the Social Service Department who is especially assigned to occupational placement. At this interview the new admission's complete work ability,

The New York City Home for Dependents publishes its own newspaper. At the left is shown one of the patients setting type. On the opposite page is an old cabinet maker.

a Welfare Island

Blind men at the looms in the Occupational Therapy Department of the New York City Home for Dependents.

Many of the women inmates sew and mend for the benefit of the institution. Others make spreads for their beds, curtains, chair-covers and other items for their own use.

his aptitudes, his inclinations, his past occupations, his attitude, his habits and his character are studied, and indicated upon a proper file card.

With a knowledge of the doctor's findings the guest is assigned to any one of the various departments in the institution. The usual percentages of the guests assigned are as follows:

Housekeeping	34%
Dietary	25%
Nursing	19%
Administration	6½%
Occupational Therapy	7%
Steward	6%
Engineering	½%

In order to clarify these percentages and assignments the complete program of occupational activities in the New York City Home for Dependents, is outlined here. The activities are divided into eight phases or branches:

1. *The Industrial and Non-Profit Activity.*—In this group are to be found the guests of the Home who are a little more able than the average type. They perform institutional work of a character which, ordinarily, would have to be paid for. They make beds, they sweep, clean, they are messengers, they iron dresses, they work in the dietary department as pantry men, waiters, bread cutters, they butter bread, clean silverware, carry food from kitchen to ward, or work in the wards of the Hospital doing some form of labor. They receive no compensation except extra tobacco for the men, or extra sugar and tea for the women, and the additional privilege of being permitted to eat at the first sitting (there are three sittings in each dining room). Three hundred and fifty men and three hundred women are found in this group. With the exception of those assigned directly to the Occupational Therapy Department the percentages indicated previously concern this group.

(*Continued on page 62*)

PRACTICAL TOPICS Featured on Tri-State Program

» » » THE TRI-STATE HOSPITAL ASSOCIATION (Illinois, Indiana and Wisconsin) scored another success in its annual convention held at the Hotel Sherman in Chicago, May 5, 6 and 7. Much credit is due the officers and committees for the very painstaking and effectual plans they had made for the meeting. Morris Dubin as chairman of the convention spent a great deal of time and thought on the arrangements and Edward Rowlands, Administrator of Martha Washington Hospital, Chicago, and Executive Secretary of the Association, must also be given a great deal of credit. These two worked untiringly and their efforts were ably supported by the various committees appointed.

The local entertainment committee under the chairmanship of Mrs. Edna Nelson, of the Women's and Children's Hospital, Chicago, arranged a variety of recreation and entertainment which afforded an opportunity for the members to meet socially without entirely monopolizing their spare time.

The Program Committee under the chairmanship of Dr. M. T. MacEachern, Associate Director of the American College of Surgeons, planned a program for the nineteen sections which made it possible for all those present to attend the general sessions as well as those of their own particular department.

The registration showed an attendance of 1,320, comprised of trustees and administrators and representing also the medical staff and other hospital personnel.

Each morning was given over to a general session, that on Wednesday morning, the 5th, being presided over by Dr. R. C. Buerki, president of the Wisconsin association. The general theme of this session was the administrative organization of the hospital. Dr. Robert Neff of the University Hospital, Iowa City, Iowa, opened the discussion by a paper on the principles underlying effectual hospital administration.

Departmental organization was then considered from the point of view of the various departments. Dr. A. S. Giordano of South Bend spoke for the clinical pathologists, discussing administrative arrangements and methods of compensation of the pathologists. Dr. Maximilian J. Hubeny, Chicago, discussed the qualifications of the radiologist and his relationship to the medical staff as an interpreter and consultant. Sister Patricia of Dulth, a guest speaker, discussed the present status of the medical records department, the qualifications of the librarian and the organization and uses of the department. Miss Helen Shuler, Indianapolis, in the absence of Miss Troutt, read her paper dealing with many practical problems in the dietary department. The point of view of the medical social worker was presented by Miss Hazel M. Halloran of Chicago.

The morning session was closed by E. Muriel Anscombe, Jewish Hospital, St. Louis, a guest speaker, who considered personnel management.

The Thursday morning session was devoted to a study of the maintenance of professional standards in the hospitals. The papers were all well thought out and much to the point. The Medical Staff was discussed by Dr. William H. Walsh, hospital consultant, Chicago; the Nursing Staff by Sister Mary Vincent of St. Joseph's Hospital, Chicago; the Pathologist by Dr. Harold D. Palmer of Rockford, Ill.; the Physical Therapist by Dr. John S. Coulter of Northwestern University Medical School; Occupational Therapy by Annette Henrich, Michael Reese Hospital of Chicago; the Dietitian by Zella L. Kester, Indiana City Hospital; and Medical Social Work by Harriet M. Barlett of Chicago.

The Friday morning session was given over to a round table discussion of various phases of work in the hospital, under the leadership of Dr. Buerki. The subjects selected were Business Methods, discussed by Stuart R. Hummell of Silver Cross Hospital, Joliet, Ill.; Medical Staff Conference by Dr. H. W. Sargeant, Milwaukee County General Hospital, Wauwatosa, Wis.; Laundry and Linen Service by Rev. H. L. Fritschel of Milwaukee Hospital, Milwaukee; Pharmacy Service by Barlow W. Hill, Ph.G., Grant Hospital, Chicago; Maintenance by Albert H. Scheidt, Indiana University Hospitals, Indianapolis, and Public Relations by Perry Addelman of Chicago.

Sectional meetings were held each afternoon and were well attended by those particularly interested in the specific section. At all the meetings it was noted that the discussion was exceedingly animated.

Nursing problems were the theme of the Illinois State Nurses' Association held Wednesday afternoon under the leadership of Alice E. Dalby, R.N., Springfield, president of the association. Papers were read by Blanche Graves, R.N., Milwaukee, Cornelia Hoeflin, R.N., Indianapolis, and Mrs. A. D. Pettee of Glencoe.

On Thursday afternoon the Illinois State Nurses' Association, the Illinois Dietetic Association, the American Association of Medical Social Workers and the Women's Auxiliary Boards met in joint session to discuss two types of cases. First, an orthopedic case was presented by representatives from Cook County Hospital. Dr. Philip Lewin discussed the case from the surgeon's point of view, illustrating his presentation with lantern slides. He was followed by Cecilia Knox,

stating the nurse's angle of the case, Lucille Bates for the dietitian and Dorothy Pearse for the medical social worker.

This was followed by a medical case presented by a group from Albert Merritt Billings Hospital. Dr. M. E. Glock led the presentation with the medical study and was followed by Helen Gonser, R.N., on nursing, Margaret Ahearn on the dietitian and Sarah Smith on social service.

The pathologists and bacteriologists met separately on Wednesday and Thursday, and on Friday afternoon the technicians of these specialties met in joint session. Subjects discussed were too numerous for specific mention, but perhaps the outstanding features brought out at the sessions were the various methods of compensation of the pathologists and their relationship to the clinical staff. It was pointed out that, in the large hospital, the director of the laboratories may be strictly a laboratory man but that, in the smaller hospital, he is becoming more and more an active clinical consultant in all phases of medicine and is expected to be a scientific leader.

Unprecedented interest was shown by the two two-hour periods allotted to anesthetists and appreciation of this was shown by the large attendance of anesthetists and hospital administrators at both sessions. Miss Willenborg of St. Joseph's Hospital, Chicago, read a paper on "What an Ideal Anesthesia Service Should Be." Clinton Smith, superintendent of Grant Hospital, Chicago, gave a splendid resume on his experience as hospital administrator and laid great stress on the importance of an anesthetic service synchronized with other services of the hospital. Mary Karp, M.D., head of the anesthetic service of Wesley Hospital, Chicago, made a great impression by pointing out the pitfalls occurring in anesthetics and stimulated a renewed vigor in further study and investigation. Miss Julia Lenihan, Frances Willard Hospital, Chicago, talked on the value of anesthetic records and follow-ups.

In addition to carrying out the regular stated program, everyone was invited to ask questions which brought forth lively and profitable discussions. There was a general feeling of good will and a resolve to make next year's meeting even superior to this one. There were four outstanding points brought out in the meetings: 1. That the head of the anesthetic service should be a qualified and trained physician; 2. that the anesthesia service should function in cooperation with the other departments of the hospital, particularly those which have to do with the study and immediate care

From top to bottom and left to right: Maurice Dubin of Chicago, and Charles A. Lindquist, Sherman Hospital, Elgin, who were re-elected president and secretary-treasurer, respectively, of the Hospital Association of Illinois. J. B. H. Martin, University Hospital, Indianapolis, and Edgar Blake, Methodist Hospital, Gary, the president-elect and president of the Indiana Hospital Association. Albert G. Hahn of Deaconess Hospital, reelected executive secretary of the Indiana group. Edward Rowland, Administrator of the Martha Washington Hospital, Chicago, and Executive Secretary of the Tri-State Hospital Assembly. R. C. Buerki, M.D., of Madison, reelected pesident of the Wisconsin Hospital Association. Below: Malcolm T. MacEachern, M.D., Associate Director of the American College of Surgeons; Josiah J. Moore, Director, Moore Clinical Laboratories, Chicago, and Fred G. Carter, M.D., Christ Hospital, Concinnati, Ohio.

of the post-operative patient; third, that too little is known about oxygen therapy and that the handling of oxygen therapy should be in the hands of the anesthesia department, and 4. that Cyclopropane is the anesthetic of the future.

Occupational Therapy occupied a more prominent position on the program than has been the case in most conventions, demonstrating the increasing importance of the department in the active hospital as well as in that for the chronic patient. An interesting meeting was held Wednesday afternoon under the chairmanship of Maude Plummer of Indianapolis, and on Thursday afternoon with Nelda Lukins of Chicago as chairman.

Physical Therapy, too, received increasing attention. At the Thursday afternoon session of the Tri-State branch of the American Association of Physical Therapists, Dr. J. S. Coulter, Chicago, presided at a session having as its theme the "Organization and Arrangement of a Physical Therapy Department with Regard to Efficiency, Economy and the Budget."

Dietetics was a prominent feature in many of the sessions but a particular meeting of the section was held on Wednesday afternoon, presided over by Mary K. Sorenson of Chicago. The papers were of an intensely practical nature.

At the opening meeting of the Record Librarians' Association Dr. Wm. Walsh, hospital consultant, outlined the "Functional Requirements in the Planning of the Clinical Record Room," illustrating his talk with slides showing various types of medical record departments. One illustration of special interest showed the largest letter file in the world located at Prague, Czechoslovakia. It consists of cabinets arranged in floor to ceiling tiers covering approximately 4,000 square feet and containing 3,000 roller bearing steel drawers 10 feet long. Desks are of the elevator type, which rise or descend, move to the right or left, stop at any drawer desired, all at the touch of a button and all operate electrically, the drawers also opening and shutting electrically. The number of employees required in this department has been reduced by this mechanical installation from 400 to 20 with a minimum of muscular effort.

"Major Problems Encountered in Record Keeping" in the University, General, Small and City Hospitals were discussed by Marion Gooden, University of Chicago Clinics, Chicago, Grace Bartle, St. Vincent's Hospital, Indianapolis, Grace Ethier, Columbia Hospital, Milwaukee, and Helen Wagoner, R.R.L., City Hospital, Indianapolis.

Dr. Clement C. Clay, Assistant Director of the University of Chicago Clinics, Chicago, Ill., outlined the desirability of a move for the adoption of standard insurance forms for proof of death and disability. Reply was made by Kenneth Cox, Manager of the Investiga-

tion Division of the Metropolitan Life Insurance Co., New York, and by Hiram Baker, Home Office Representative of the Prudential Insurance Company of America, Chicago.

The round table discussion on the second afternoon, led by Dr. Buerki, brought forth many interesting details on subjects both old and new. Two suggestions were brought out during the meeting that Dr. Buerki felt would be worthwhile taking home, if no other benefit was derived from the discussion. The first was the amount of clerical or other assistance given to members of the medical staff. A practical suggestion was reference to a special committee (record committee) to decide the work to be done and make recommendations. The other point brought out was that in releasing information legally signed authorization from the patient is all that is required for the protection of the hospital, but that it is the courteous thing to do to also ask the permission of the attending doctor.

The Social Service section on Wednesday afternoon was presided over by E. I. Erickson, Chicago. Other sections meeting in individual session were the Housekeepers, Engineers, Auxiliary Boards, Medical Staff Officers, Directors of Out-Patient Clinics and Accountants.

A particularly interesting meeting was that devoted to the small hospital under the chairmanship of Gladys Brandt, R.N., of Logansport. The meeting took the form of an informal discussion between those present and members of the personnel responsible for food service, housekeeping and nursing service in the hospital. A very enlightening innovation at this meeting was that of having representatives of some of the merchandising firms meet with the hospital people to discuss their impressions of each other and means of making their relationship mutually beneficial.

On Wednesday evening there were several dinners. After the trustee's dinner in the Grand Ballroom, Dr. E. M. Bluestone, Director of Montefiore Hospital, New York, very ably discussed the labor situation as it is today in his papers, "Labor and Philanthropy." Guy Clark of the Cleveland Hospital Council followed with a report of the development and present status of the Cleveland Hospital Council. The dinner was closed by one of those witty and able addresses which only Robert Jolly knows how to deliver. His subject was the Hospital Appeal and certainly his method of handling it would go a long way toward inducing philanthropists to divert some of their surplus wealth to the use of hospitals.

The formal Tri-State Banquet on Thursday evening, sponsored by the Chicago Hospital Association, filled the Grand Ballroom. Dr. Malcolm MacEachern was introduced by E. I. Erickson, President of the Chicago Hospital Association, and acted as toastmaster. Dr. MacEachern, in his usual affable manner, introduced those at the speakers' table and ended this part of his duties by presenting Dr. Bert W. Caldwell, Executive Secretary of the American Hospital Association, who conveyed the greetings and good wishes of the National Association to the present gathering. Dr. MacEachern then introduced Dr. Glen Frank of Madison, Wis., who gave a very able address on Society and Government. The dinner was followed by a dance and program.

On Friday noon a luncheon was held to which all those attending the convention were invited and a program of entertainment was put on by the Glee Club of the Cook County School of Nursing.

The exhibits were well worthy of notice and were arranged in such a manner that they could be seen by those present without any waste of time or effort. One hundred and sixty-eight exhibitors had on display various articles of all types which are used in the hospital, and showed the usual courteousness and willingness to explain or demonstrate at any time. Much of the success of the convention is due to this spirit of the members of the Exhibitors' Association.

Business meetings of each of the state associations were held at various times during the convention, and the following officers were elected:

Hospital Association of Illinois: President, Maurice Dubin, Chicago; First Vice President, Stuart Hummel, Silver Cross Hospital, Joliet; Secretary, Charles A. Lindquist, Sherman Hospital, Elgin, Ill.

Indiana Hospital Association: President, Edgar Blake, Methodist Hospital, Gary; President-Elect, J. B. H. Martin, Indiana University Medical Center Hospitals, Indianapolis; Secretary, Albert G. Hahn, Deaconess Hospital, Evansville.

Wisconsin Hospital Association: President, R. C. Buerki, M.D., Madison.

In the News

1937 Convention of the A.H.A.

» » It is not too soon to begin thinking about attending the annual convention of the American Hospital Association. It is valuable to trustees and others interested in the hospital field as well as to administrators.

The convention will be held this year at Atlantic City from September 13 to 17, inclusive. We are informed that preparation of the program is well underway and that it will be, if possible, better than ever. Those who have attended previous conventions at Atlantic City and know its facilities for both work and play will need no urging but will make every possible effort to be present.

Western Hospitals Hold Successful Convention

» » A most successful convention was held April 12 to 15 by the hospitals of eleven western states. Over two thousand delegates registered and attended the sessions at the Biltmore Hotel in Los Angeles, Calif., which featured a number of new innovations and departures from past policies. Instead of the usual convention with a competing three-ring circus and a consequently over-crowded program, the program committee chose to very thoroughly develop and discuss six major topics.

The first session considered the subject, "The Manifold Obligations of Hospitals to the Public." Benjamin W. Black, M. D., Medical Director of the Alameda County Institutions, gave the opening address and in his characteristic manner ably handled the subject, starting the program off with the proper enthusiasm and momentum. He emphasized that although hospitals do have manifold obligations, the primary obligations of hospitals is patient welfare and that all other obligations are subsidiary thereto. He stressed among others, the obligation of leadership in public health, teaching, and in public education.

On Tuesday morning, the convention was addressed by Howard Burrell, Attorney, Los Angeles, on "Legislation and Hospitals." Handling this in a proper neutral attitude, Mr. Burrell crystallized the attention on the various types of legislation confronting hospitals at the present time. He went further than actual legal code and discussed court decisions which have become equally as important as legislation. This session proved to be not only a study of the history of legislation but a guide for future legislative policies for hospitals.

Tuesday afternoon, the convention was addressed by Frank Van Dyk, Executive Director, Associated Hospital Service of New York, and C. Rufus Rorem, Ph.D., Director, Committee on Hospital Service of the American Hospital Association, the subject being "Group Hospitalization." Both Doctor Rorem and Mr. Van Dyk proved to be competent authorities on this problem, Doctor Rorem from his long study of this problem under the American Hospital Association and Mr. Van Dyk in light of his experience as director of the largest Hospital Service Plan in the United States, now numbering nearly 350,000 members. Both of these speakers emphasized the public service of this plan of budgeting sickness cost, particularly pointing out that Group Hospitalization is primarily a solution of the patient's economic problem and only incidently beneficial to the hospitals. R. E. Heerman, Superintendent, California Hospital, led the discussion hour and emphasized that in Southern California the hospitals themselves were anxious and ready to proceed. Twenty-seven hospitals having already signed qualifying papers were held up by the necessity of legislation now under consideration at Sacramento enabling their Association to proceed.

On Wednesday morning, Claude W. Munger, M. D., President, American Hospital Association, addressed the convention on "The Interest of the Patient is Paramount." He stressed the responsibility of the hospitals for providing scientific progress to assure safety and proper sanitation facilities—but beyond these, which he considered minimums in hospital care, he stressed the necessity for considering the new psychological aspects of the care of patients. He emphasized the necessity of further study in psychiatrics, the training in this subject of nurses, doctors, and the public. He predicted that far greater use of this modality can be expected and that the benefits will be surprisingly beneficial. He placed particular attention on the science of dietetics and predicted further development in this line.

Wednesday afternoon the session was opened by B. C. MacLean, M. D., who addressed the convention on the subject "The Growth, Causes and Cures of Malpractice Suits." Doctor MacLean very ably presented the problem and through the use of lantern slides gave interesting statistics supporting his discussion. His address was a very capable presentation of a serious hospital problem. Following Doctor MacLean's address, the convention staged one of its interesting innovations, namely, a mock trial of a malpractice suit. This session proved to be highly interesting and entertaining as well as instructive on this grievous problem. The case of McGillacudy vs. Lying Down Memorial Hospital will long be remembered by the many delegates who packed the assembly room and willingly remained forty-five minutes beyond the prescribed hour of adjournment. The trial was conducted realistically under the leadership of Roland Maxwell as Judge, William Rains as Prosecuting Attorney, and Raymond G. Stanbury as Defense Attorney. Many common errors and mistakes were dramatized and searchingly driven home by examination and cross-examination. The law on the subject was very interestingly presented by Judge Maxwell in his charge to the Jury. The verdict was in favor of the Plaintiff.

At 8:30 on Wednesday evening, the delegates assembled at the Biltmore Rendezvous for their annual banquet. A very high spiritual note was introduced into the convention by Professor Ordway Tead, Columbia University, who addressed the banquet guests on "Can we have Faith in the Future?" The delegates enjoyed themselves as is testified by their dancing to the excellent music provided beyond the midnight hour.

On Thursday morning, delegates of the convention listened to an address by Doctor Ordway Tead, Lecturer on Personal Administration, Columbia University, on the subject, "Employee Welfare in the Broader Sense." Doctor Tead emphasized the necessity of promulgating in the employee group itself the high motives of hospital service. He drove home the necessity of studying administration itself as scientifically as doctors do the practice of medicine. He candidly discussed the problem of labor unrest which for the first time has reached out and affected hospitals. He urged that administrators approach this problem with an open mind and do the job constructively rather than obstructively. In the discussion which followed later, under the leadership of Wm. P. Butler, a very spirited attack was made upon this problem.

In addition to these general assemblies, sectional programs of exceptional merit

were provided by Auxiliary and Volunteer services—cancer clinics, dietitians, hospital pharmacists, trustees, medical social workers, public hospital administrators, and record librarians. Capacity audiences attended all of these sessions and were highly pleased with the programs presented. The consensus of the delegates, assemblying in greater number than ever before, is that this was the most interesting and successful convention ever held on the Pacific Coast.

International Hospital Association

» » The following provisional program has been arranged for the fifth International Hospital Congress, to be held in Paris July 5 to 11:

Monday, July 5—3 p. m., formal opening of the Congress and first plenary session; 6 p. m., reception at the Hotel de Ville, Paris.

Tuesday, July 6—9 a. m., second plenary session; 2 p. m., meetings of Study Committee and their sub-committees, according to order of business previously arranged by the respective chairmen; 5 p. m., private session of the Administrative Council of the International Hospital Association.

Wednesday, July 7—9 a. m., third plenary session; 2 p. m., technical visits.

Thursday, July 8—9 a. m., meeting of Study Committees and their sub-committees according to order of business previously arranged by the respective chairmen; 3 p. m., sub-committee on the Moral and Spiritual Care of the Sick; 6 p. m., sub-committee on hospital libraries.

Friday, July 9—9 a. m., fourth plenary session; 2 p. m., technical visits; 5 p. m., Study Committee V.

Saturday, July 10—9 a. m., fifth plenary session; 3 p. m., meetings of the Administrative Council of the I.H.A.

Sunday, July 11—9 a. m., sixth plenary session; 3 p. m., reports and resolutions by Study Committees; 6 p. m., formal closing of the Congress.

Michigan Hospital Association

» » Michigan Hospital Association held a very successful meeting at Ann Arbor, April 15 and 16. Officers elected for the year 1937 were:

President, Miss Mary Skeoch, St. Luke's Hospital, Marquette; first vice-president, Ralph M. Hueston, Hurley Hospital, Flint; second vice-president, Harry Gault, Women's Hospital, Flint; third vice-president, Miss Elizabeth Waddell, Women's Hospital, Detroit; secretary, Robert G. Greve, Hackley Hospital, Muskegon; treasurer, Miss Amy Beers, Hackley Memorial Hospital, Muskegon.

It was decided to hold the 1938 convention at Marquette during the third week in June.

Awards for Employees of Deaconess Hospital

» » The personnel of the Deaconess Hospital and other citizens of Evansville, Ind., will be presented with distinguished service award certificates for their faithfulness to the hospital during the Ohio River flood.

The unselfish decision of the personnel at the time of the crisis warrants these certificates of award. All agreed first to care for the patients and give them first consideration if evacuation should become necessary, second to save the hospital property, and last to protect their own lives from the rampaging Ohio. Everyone agreed to follow this code of ethics as established by the hospital.

The presentation meeting will be held in the Hospital Solarium on Monday, May 17, with the personnel presenting the entire program.

Mease Hospital Open

» » The new Mease Hospital, Dunedin, Florida, was formally opened to public inspection on April 17. The hospital, representing an investment of more than $100,000, is equipped with the most modern hospital equipment available. It is completely air-conditioned and has complete physical therapy equipment. Tampa physicians expressed the opinion that Mease Hospital is the only hospital in Florida that is completely equipped for physical therapy.

THE HOSPITAL CALENDAR

May 20-22—Hospital Association of New York, New York City.

May 27-28—New Jersey Hospital Association, Atlantic City, New Jersey.

June 2-4—Hospital Association of Pennsylvania, Buck Hill Falls, Pa.

June 10-11—Mid-West Hospital Association, Colorado Springs, Colo.

June 24-25—Manitoba Hospital Association, Brandon, Canada.

July 5-11—International Hospital Association, Paris, France.

Sept. 13-17—American College of Hospital Administrators, Atlantic City.

Sept. 13-17—American Occupational Therapy Association, Atlantic City.

Sept. 13-17—American Protestant Hospital Association, Atlantic City.

Sept. 13-17—Children's Hospital Association, Atlantic City.

Sept. 13-17—National Association of Nurse Anesthetists, Atlantic City.

Sept. 13-17—American Hospital Association, Atlantic City.

July, 1937—Hospital Association of Nova Scotia and Prince Edward Island, Sydney, Nova Scotia.

Oct. 25-27—Ontario Hospital Association, Toronto, Canada.

Oct. 30—Kansas Hospital Association, Newton, Kans.

Ontario Mental Hospital To Be Enlarged

» » The premier of Ontario has made provision in the 1937 budget for an expenditure of $2,650,000 on the extension of mental hospitals, which will include a new mental hospital at Port Arthur. New buildings will be erected at Hamilton at a cost of $300,000, and at Woodstock the construction of two units for epileptic children will be undertaken. The government will begin a program of modernizing and fire-proofing at Brockville, Cobourg, Kingston, London, Hamilton, New Toronto, Orillia and Penetanguishene. It is the intention of the government that practically all of this work will be done by private contract for which tenders will be invited.

Health Insurance in British Columbia Indefinitely Postponed

» » *Canadian Hospitals* reports that the proposed compulsory health insurance measure in British Columbia, Canada, has been postponed indefinitely. This is said to be largely due to the opposition of the medical profession to a measure which did not make any provision for the indigent or those who are unable to pay, and which, it appeared, would not give adequate remuneration for services to those insured. Arrangements are said to have been made with the British Columbia Hospital Association concerning the hospitalization of patients if and when the act goes into force. The proposed British Columbia act is among the most advanced in the field of socialized medicine on this continent.

Superintendent Honored By Hospital Group

» » Miss Mary Bell May, superintendent of nurses at Presbyterian Hospital, Charlotte, N. C., was made an honorary member of the Presbyterian Hospital Alumnae Association at a meeting of the association held recently.

Miss May was honored because of the interest she has shown in the society and her many contributions to the welfare of the nurses, it was said. A second motion was made and carried to confer the honorary membership on all the living former Presbyterian hospital supervisors as a sign of respect and gratitude for their service, as follows: Miss Ella MacNichols, Shelby; Miss Eugenia Henderson and Mrs. Parks M. King, both of Charlotte; Miss Virginia O. McKay, formerly of Asheville.

Benedictine Sisters Get Loan to Build Hospital

» » A private loan for a new $50,000 hospital in Morrilton, Ark., has been obtained by the Benedictine Sisters, owners and operators of St. Anthony's Hospital here. Work on the new building, which will be two stories high, will be started at once.

National Health Food Show To Boom Industry

» » America's first major Health Food Exhibition, the Chicago Health Food and Appliance Exposition to be held at the Coliseum, May 21st to 25th inclusive, will be the biggest show of its kind ever held, according to final plans just announced.

With health food and appliance firms all over the country contracting for space, there is every indication for a wide diversification of exhibits, including latest products in the Health Food Line, as well as the old standard brands. Several nationally known sanitoria will be represented, and Health Appliance Manufacturers will display their newest devices for securing and maintaining health.

Rolling Hospitals Ready For Use in Major Disasters

» » Oklahoma has one of the best medical service set-ups in the country in event of major disasters, strictly as a by-product of its regular health work.

The state has two hospital trailers which can be used immediately for emergency service. Both can be turned into complete operating rooms, including X-ray machines and other equipment. The beauty of these trailers is that they're not just for emergencies," states Doctor Pearce, State Health Commissioner. "We are using them every day, one for school clinics and the other for tuberculosis control work."

Since the trailers are designed for use in rural areas where electric power is not available, both carry their own generators, and need not depend on power lines. The trailers cost the state approximately $1,600.

Foote Nurses Get $10 Pay Increase

» » Pay increases of $10.00 per month for all general duty nurses of Foote Hospital, Jackson, Mich., were authorized by the board of managers and announced recently by Superintendent Harold F. Dold.

It is the fifth boost in nurses' salaries at the institution since February, 1936, and raises the pay from $45.00 per month, the figure at which the increases began, to $75.00 per month.

Duke Endowment Assistance To Carolina Hospitals

» » The Duke Endowment recently increased the allotment to hospitals and orphanages in the Carolinas by distribution of an additional $939,499.30. This brings the total amount paid in assistance to hospitals and orphanages to $11,500,000. Of the present allotment, ninety-five hospitals received $824,213.00 and twenty-eight others will apply for approximately $148,000.00 on the basis of $1.00 per day of free care given in 1936.

Shrine Hospitals

» » Easter week was set aside by Shriners in 159 Temples in the United States for the purpose of holding programs to raise funds for the Shrine Hospitals for Crippled Children.

United Hospital Fund Of New York

» » The United Hospital Fund of New York held a dinner dance on the evening of April 13, at the Hotel Commodore in furtherance of the effort to secure uniform accounting in the hospitals of the city. It is reported that such an effort, which has been going on for seven years, has met with a degree of success and by annual meetings of this type as well as by actual classes still further improvement in hospital accounting in the city is expected.

Toledo Police Give $158 To Hospital Fund

» » The Toledo Police Department recently presented $158 to county commissioners to be used in furnishing a room at the new William W. Roche Tuberculosis Sanatorium. The room is to be named for the department. Commissioners have received a total of about $4,000 from various persons and organizations to furnish memorial rooms in the hospital. Cost of equipping a single room is about $158.

Manteno Hospital Fourth Largest in U. S.

» » The $4,500,000 building and improvement program, making the Manteno (Ill.) State Hospital for Mental Diseases the fourth largest state hospital in the United States, is nearing completion. In a report from State Welfare Director A. L. Bowen, he said that "altogether $10,000,000 now has been expended on the development of the Manteno hospital."

Capacity of the hospital when completed will be 6,300 beds. The present building program will provide 3,300 new beds.

Corrections

» » Our attention has been called to an error in the discussion of bed occupancy in mental hospitals, based on the statistics published by the American Medical Association. The statement should read that in 1935 there were 22,042 unoccupied beds, or 4.2 per cent of the total, whereas in 1935, 23,959 unoccupied beds were 4.4 per cent of the total beds available.

Due to a typographical error, it is stated on the front cover of the April issue of this magazine that Matthew O. Foley was editor from December, 1930, to January, 1935. Mr. Foley was connected, in an editorial capacity, with HOSPITAL MANAGEMENT from 1920 until his death in 1935.

Indian Hospital Dedicated

» » The Indian Hospital at Wagner, S. D., for the care of the Yankton Sioux, was formally dedicated in April. The new building cost $93,000, and is modern in every respect. It is proposed to build a residence for employes on the grounds of the hospital, at a cost of $30,000.

Archbold Hospital Given $10,000 for X-Ray Equipment

» » Announcement has been made of a gift of $10,000 from Hendon Chubb. Thomasville Winter resident from Old Saybrook, Conn., to the John D. Archbold Memorial Hospital, Thomasville, Georgia, the fund to be used for the purpose of improving the X-ray department of the institution. The present plans are for the installation of entirely new and most modern and effective equipment throughout the X-ray department, to make it a department unexcelled in this section of the country.

National Conference Of Social Workers

» » A national conference of Social Workers will be held in the Athenaeum, in Indianapolis, Ind., in May. The business meeting will be held Monday afternoon, May 24th. There will be general meetings Tuesday afternoon, a banquet Thursday evening and general meetings Friday afternoon.

Hospital Wing Opened

» » A new $30,000 four-story addition to the King's Daughters Hospital, Madison, Ind., was formally dedicated recently. It is to be known as the Dr. Thomas and Martha J. Sanderson addition. The new wing increases the hospital capacity from twenty-five to fifty beds.

Hospitals Merged

» » The facilities and personnel of a hospital operated at Estherville, Iowa, by Doctor C. E. Birney have been merged with the Coleman Hospital, according to a recent announcement. The Coleman Hospital is a three-story, thirty-bed institution, with a staff of seven physicians and ten nurses.

Marion Hospital Fire

» » Fire of undetermined origin recently destroyed the mess hall of the United States Veterans Hospital at Marion, Ind. Damage was estimated to exceed $300,000 and no insurance was carried.

Air Conditioned Hospital Being Built in Persian Desert

» » Out on the arid desert sands of Abadan, Persia, where vast deposits of crude oil lie hidden beneath the age-toasted earth, a new group of buildings, including a hospital, is being built by the Anglo Iranian Oil Company. The group includes the oil company's field offices, an engineering department building, a desert transportation division building and a staff hospital. While the geographical name, Persia, is used here, Abadan is, strictly speaking, in Iran, the native name of Persia which is still used.

The hospital is being built to safeguard the health of the oil company's employes because illness and sunstroke hazards are so great in this hot, arid desert country. Abadan, too, is a long distance from "civilization." The most modern scientific medical equipment is being installed, including air conditioning. The air conditioning problem is an extremely important one because of the temperature and humidity peculiarities in the desert country.

The hospital consists of three sections: a large division containing general and private wards; an operating and X-ray department, and a heat or sunstroke ward.

Chico, Calif., Gets New Hospital from Dr. Enloe

» » Chico, Calif., now has a new hospital, which bears the name of its owner, Dr. N. T. Enloe. The hospital was built at a cost of $100,000. It contains 52 beds with special emergency and surgery rooms with all the latest equipment.

Sisters of St. Francis Honored by Chinese

» » The Hospital Sisters of St. Francis at Springfield, Ill., received an interesting account of the gracious bestowal of a solemn mark of esteem upon the missionary sisters of the order stationed at St. Joseph's Hospital in Tsinanfu, China, by officials of the Chinese government.

A few days before the feast of Christmas a delegation of thirty or more prominent local Chinese, among them representatives of the governor and mayor, accompanied by a band of musicians, paid a formal call on the sisters. The delegation presented the sisters with a large oriental panel on which are carved Chinese characters expressing the gratitude they felt for the many kind deeds rendered in behalf of the poor.

Administrative Changes In N. Y. Hospitals

» » S. S. Goldwater, M.D., Commissioner of Hospitals in New York City, has announced a series of changes in the administrative staff of the Department of Hospitals.

Edward M. Bernecker, M.D., has been promoted from medical superintendent of Kings County Hospital to general medical superintendent of the Department, assigned to field work. Dr. Bernecker replaces Adam Eberle, M.D., who has been appointed senior general medical superintendent, succeeding Mark L. Fleming, M.D., who recently retired.

Emanuel Giddings, M.D., medical superintendent of Morrisania Hospital, has been promoted to medical superintendent of Kings County Hospital. Henry Greenberg, medical superintendent of Fordham Hospital, replaces Dr. Giddings at Morrisania. Stephen H. Ackerman, medical superintendent of Coney Island Hospital, is now medical superintendent of the Fordham Hospital, and C. G. McGaffin, M.D., medical superintendent of the Children's Reception Hospital, has been transferred to the Coney Island Hospital.

PERSONALS

● MORRIS HINENBURG, M. D., executive director of The Jewish Hospital, Brooklyn, N. Y., has announced his resignation to accept a combined administrative and clinical position as superintendent and medical director of the Denver Sanatorium of The Jewish Consumptives' Relief Society, Denver, Colo., on June 1, 1937. Doctor Hinenburg was formerly assistant director at Montefiore Hospital for Chronic Diseases, New York City.

● HAROLD M. SALKIND has been named acting superintendent of Beth Abraham Home for Incurables, Bronx, N. Y., a 250-Bed chronic institution. Mr. Salkind fills the position made vacant by the resignation of Emil Greenberg. He was formerly assistant superintendent of the Brooklyn Jewish Hospital with which he was connected for nine years. He is editor of *The American Interne.*

● STEPHEN H. ACKERMAN, M. D., formerly superintendent of Coney Island Hospital, has been appointed medical superintendent of Fordham Hospital, New York City.

● HAROLD M. COON, M. D., medidical director of River Pines sanatorium since 1934, and actively connected with the institution since 1923, has been appointed superintendent of the Wisconsin State Sanatorium at Statesan, near Wales. Doctor Coon will succeed Doctor R. D. Thompson, who resigned to take charge of a state tuberculosis sanatorium at Orlando, Fla. Doctor Coon's father, Doctor John W. Coon, was superintendent of the Statesan sanatorium from 1909 to 1915, prior to his coming here in 1917 to become medical director and president of River Pines. Doctor Harold Coon will leave his position as medical director at River Pines, which he has held since his father's death in September, 1934, to accept the new position.

● F. STANLEY HOWE marked the tenth anniversary of his appointment as superintendent of Orange Memorial Hospital, Orange, N. J., on April 13th. No other superintendent has served as long during the hospital's sixty-three years.

● H. Y. SWAYZE, M. D., of Kerville, Tex., has been appointed superintendent of the Kerville State Sanatorium for tubercular negroes. Doctor Swayze, whose appointment became effective April 1, has been associated with the operation of a private hospital owned by Doctor S. E. Thompson at Kerville for the past nineteen years. Ultimately, the new negro hospital will accommodate 200 patients.

● LEONARD A. LUBBOCK of Princeton, N. J., will succeed Major A. Gordon Cummins as superintendent of Faxton Hospital, Utica, N. Y. Mr. Lubbock has been engaged as a hospital consultant and has made a study of administration, operation, financing and construction. He was at one time assistant administrator of an institution at Elizabeth, N. J., and since 1933 has served as superintendent of Princeton Hospital.

● JOHN E. GORRELL, M. D., formerly superintendent of the Falk Clinic of the University of Pittsburgh, took over his duties as superintendent of Blodgett Memorial Hospital, Grand Rapids, Mich., on April 1.

● NORBERT A. WILHELM, recently assistant superintendent at Peter Bent Brigham Hospital, has assumed his new position as superintendent of Butterworth Hospital.

● MISS GRACE P. HASKELL, R. N., superintendent of the Wentworth Hospital, Dover, N. H., has resigned following thirty-one years of service. Miss Haskell is the first and only superintendent the hospital has had. She resigns to take a much needed rest from professional duty.

● MISS JUNE MOE has been appointed superintendent of Oneida City Hospital, Oneida, N. Y.

● For thirteen years an X-ray technician at the Walter Reid Hospital in Washington, D. C., MANUEL PAVAO, JR., has been transferred to Honolulu, Hawaii, where he will assume a similar position at the Tripley Hospital.

● MRS. MARGUERITE MATHEWS has been appointed chief of the nursing staff of the new $100,000 Michigan City Sanitarium at Michigan City, Indiana, according to an announcement made by officials of the institution.

● GEORGE W. MORROW, M. D., has been appointed acting manager of the Kankakee State Hospital, Kankakee, Ill., succeeding Doctor Robert R. Smith, who resigned recently.

● MRS. R. H. MORGAN, formerly in the record librarian's office at the Georgia Baptist Hospital, Atlanta, Ga., has accepted a position with the Baptist Hospital of Birmingham, as head record librarian.

DEATHS

● FRANCIS FLEURY PRENTISS, president of the Board of Trustees of St. Luke's Hospital, Cleveland, for thirty years, died in St. Luke's Hospital, Pasadena, Calif., on April 1st. He is survived by his wife, Mrs. Francis F. Prentiss, a brother and a sister.

In 1906, Mr. Prentiss, with others, became interested in St. Luke's Hospital when it was a small institution known as the Cleveland General Hospital, located on Woodland Avenue. A new building was soon erected at 6606 Carnegie Avenue. In 1923, another site at East 116th Street and Shaker Boulevard was purchased and the present hospital buildings were erected.

Mr. Prentiss' gifts to the institution during his lifetime amounted to more than $3,000,000. More valuable, however, than the money he gave was his distinguished leadership. He gave himself freely as well as his time and money to the advancement of the hospital. Every week he was in the city he called at the hospital for a conference with the superintendent. He was interested in every detail of the operation of the institution. To him membership in the Board of Trustees was a public trust.

The death of Mr. Prentiss is an irreparable loss to St. Luke's Hospital as well as to other institutions with which he was associated. He provided most generously for the institution in his will, his bequests amounting to several millions of dollars.

● MISS PERRY HANDLEY, superintendent of the American Hospital, Paris, France, died April 17th. Miss Handley was born in Sydney, Australia, and began her nursing career in 1909 in a California hospital, where she was a supervisor until 1914. She went overseas with the Whitney unit under Doctor William Martin. She served four months with the French Red Cross on the front and later with the American Red Cross in Serbia and Poland for several years.

● DAVID A. STEWART, M. D., Superintendent of Ninette Sanatorium, and an international authority on tuberculosis, who died recently at the Winnipeg General Hospital, was one of the outstanding medical writers in this country. Interested as he was in literature, biology, geology, and in etching, to mention but a few of his many hobbies, the many productions of his pen and stylus were a never-ending source of joy and delight to his wide circle of correspondents. Those who were privileged to know Dave for many years have a feeling of personal loss.

● PAUL H. RUPP, M. D., 55, superintendent of the County Hospital for the Chronic Insane, Wauwatosa, Wis., died on April 6 at the County General Hospital. He had been ill five months and failed to recover from an operation performed Dec. 1.

Doctor Rupp had spent twenty-two years in public health work, having given up private practice in 1915 to become acting alienist in district and municipal courts. Upon the death of Doctor William F. Bentler in 1929, he was appointed to the superintendency of the insane asylum, a position he had held ever since.

● ROBERT E. DAVISON, M. D., 66, former president of the Suburban General Hospital at Bellevue, Pa., died April 18th while playing golf at the Highland Country Club.

PROJECTS

● University of Maryland Hospital, Baltimore, Md., will receive $140,000 from a recently authorized State bond issue with which two additional floors will be erected on the 10-story hospital building, increasing the capacity by approximately 94 beds.

● The State Senate of Missouri has passed a bill providing for construction of a $5,000,000 Cancer Hospital at Columbia and establishment of clinics throughout the state.

● The State Board of Control, Austin, Texas, is having plans prepared for a ward building at the State Tuberculosis Sanitarium for Negroes. It will be two stories, and will cost approximately $96,000.

● The State Board of Control of Florida, Chattahoochee, has awarded contracts to B. L. Brewer, Thomasville, Ga., for construction of a men's dormitory costing $24,146, and bachelor doctor's quarters costing $16,671, at the Florida State Hospital.

● An X-ray building to cost more than $45,000 will be built by the Salem Hospital, Mass., as part of a general program of improvement and expansion.

● Staples (Minn.) new $60,000 municipal hospital was opened for inspection last month. Completed last November, it was constructed under a PWA grant with the aid of a $30,000 bond issue.

● Sacred Heart Hospital, Tomahawk, Wis., conducted by Sisters of the Sorrowful Mother, will have a new addition, which will include an X-ray department, two new operatnig rooms, nursery and maternity ward. These rooms are to be sound proof and the addition is completely fireproof. The old building will also be remodeled.

● Workmen have started to raze the south central section of St. Anthony's Hospital in Davenport, Iowa, to make way for a $200,000 five-story addition to be built there. The section being torn down was built in 1893. The new wing will be modern in every detail with the top floor given over to surgical rooms.

● Construction of four new buildings at three state institutions, all to cost approximately $995,000, has been approved by the State of Indiana Budget Committee. A 160-bed dormitory at the Central State Hospital, Indianapolis, was included among those given approval. Approval was also given for construction of a hospital and dormitory, each to cost about $250,000, at the Logansport State Hospital. For the Richmond State Hospital, approval of a hospital unit to cost about $250,000 was given.

● A $100,000 addition will be built at St. Agnes Hospital in White Plains, N. Y. Two of the three wings of the building will be extended to add facilities which will include thirty-nine private and semi-private rooms.

● Bids have been opened by the Hutchinson County Commissioners' Court for construction of a $65,000 county hospital in Borger, Texas.

● Plans for the construction of a new, home-financed, $1,000,000 city-county hospital unit adjoining the present Erlanger Hospital, Chattanooga, Tenn., will be finished around July 1.

● The Turner Construction Company has been awarded general contract for the erection of an infirmary building and a nurses' home for St. Christopher's Hospital for Crippled Children in Philadelphia, Pa. The building will be three and five stories.

● Three new buildings—a central dining room and two dormitories—have been recommended by the house institution appropriation committee and by the state budget officer for the Northern Oklahoma Hospital at Enid. The dining room and one dormitory will be erected the first year and a similar dormitory will be erected the second year.

● The City Board of Commissioners of Paducah, Ky., have selected a site for a proposed $400,000 hospital to replace Riverside Hospital, damaged by flood. The board will apply for federal funds. The proposed building will be three stories high, fireproof and of 250 beds capacity.

● A bill has been signed authorizing Allegheny County, Md., to issue bonds in the amount of $150,000 for alterations and additions to Memorial Hospital.

● The Sisters of Charity of the Incarnate Word, San Antonio, Texas, plan a 40-room addition to St. John Hospital. It will be of brick and reinforced concrete, with a built up roof and concrete floors.

● Rollins Brooks Hospital, Lampasas, Texas, is having plans prepared for an addition which will enlarge the laboratory and clinical space and increase the bed capacity. Excavation for the foundation was started early in April.

● Jackson Memorial Hospital, Lexington, Va., is having plans prepared for a $20,000 hospital addition. Bids will be called for in June.

● David Memorial Hospital, Elkins, W. Va., has awarded a contract amounting to $75,000, to R. H. Daniels, Elkins, for construction of Katherine Hitt Memorial Home for Nurses.

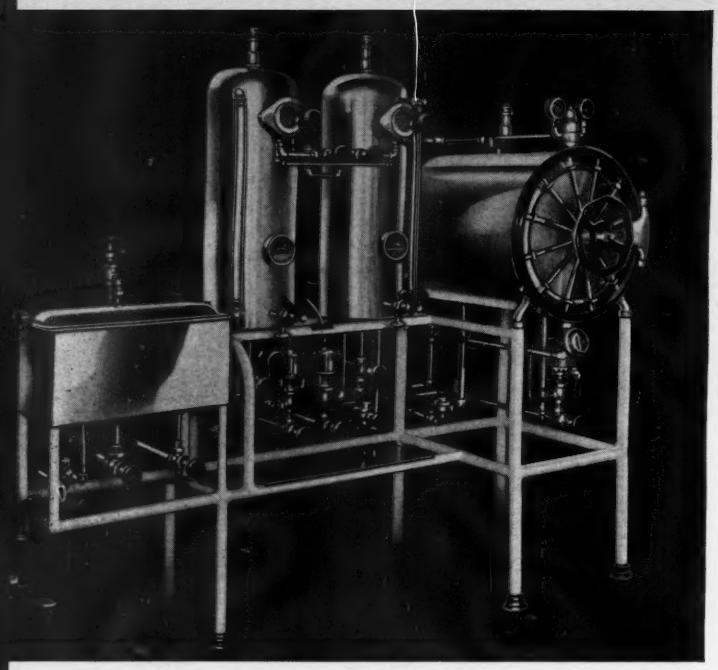
● The City of Hawkinsville, and Pulaski County, Ga., are having plans prepared for a $75,000 hospital of approximately 35-bed capacity. It will be fireproof.

● The Methodist Hospital, Pikesville, Ky., is planning a fourth floor addtion to cost approximately $10,000.00.

D

Department of Nursing Service

FOR THE SURGERY



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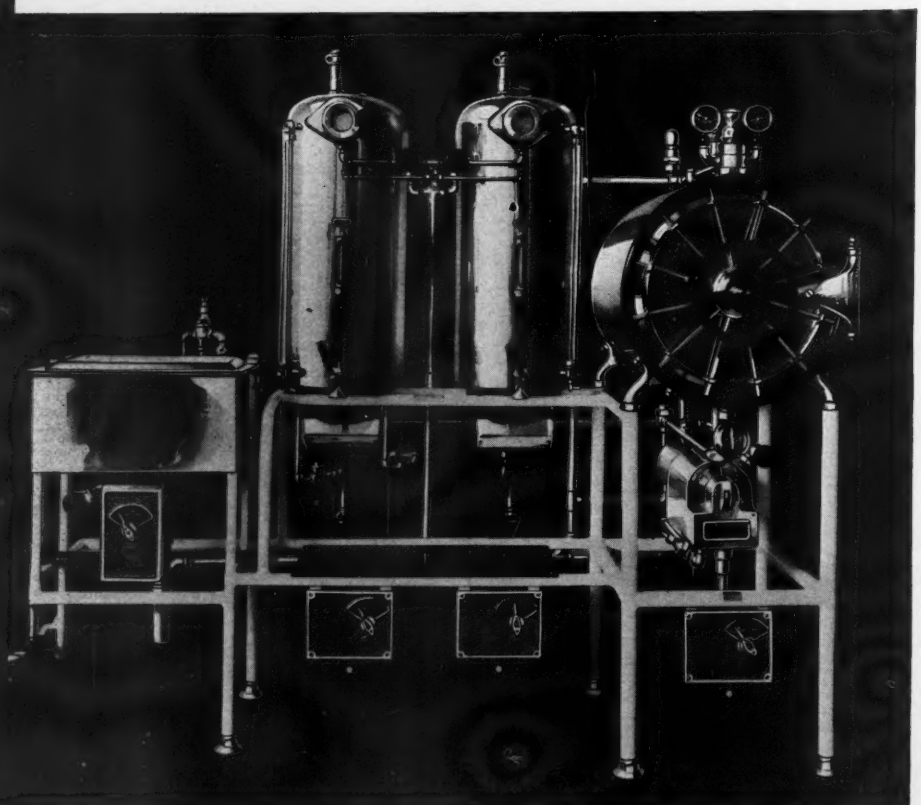

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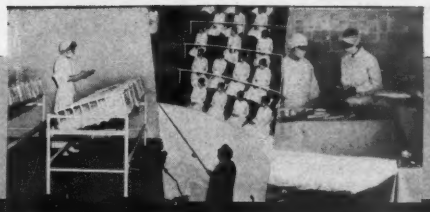


DEPARTMENT OF NURSING SERVICE

Janet Fenimore Korngold

Director, School of Nursing, St. Luke's Hospital, Chicago, Ill.,
Editorial Director

ALTERNATING PRESSURES IN THE TREATMENT OF PERIPHERAL VASCULAR DISTURBANCES

By EUNICE ANNE ROTH, R.N.

Illinois State Research Hospital, Chicago, Ill.

» » » "NURSE, I feel like a colt this morning," said O-W, after thirty one-hour treatments of Vascular Therapy. O-W, a man of seventy-six, had come to the clinic complaining of dull aching pains in the calves of his legs and constant burning on the soles of his feet. This had been present for one month. The pain was greatly aggravated by walking and relieved by rest. The case was diagnosed Arterio-Sclerosis, and treatments were started. Owing to lack of space he was able to get only one hour weekly for a period of six weeks; it was then increased to one hour twice a week. After twenty hours of treatment the patient reported a decided improvement, and after forty-five hours the pain in the legs had almost entirely disappeared and he was able to walk several blocks without discomfort. The burning on the soles of his feet was very much lessened also, and treatments were discontinued. Reporting back to the clinic two months later, the patient was still enjoying considerable activity with freedom from pain.

The use of alternating pressures in the treatment of Peripheral Vascular disturbances, though experimented upon from time to time since Nathan Smith built the first "vapor bath" with an attached air pump in 1798 in Sussex County, England, did not become of practical use until after the intensive work of Herrmann and Reid on vascular diseases in the Cincinnati General Hospital, during 1932 and 1933, and the development by them of the Pavaex unit.

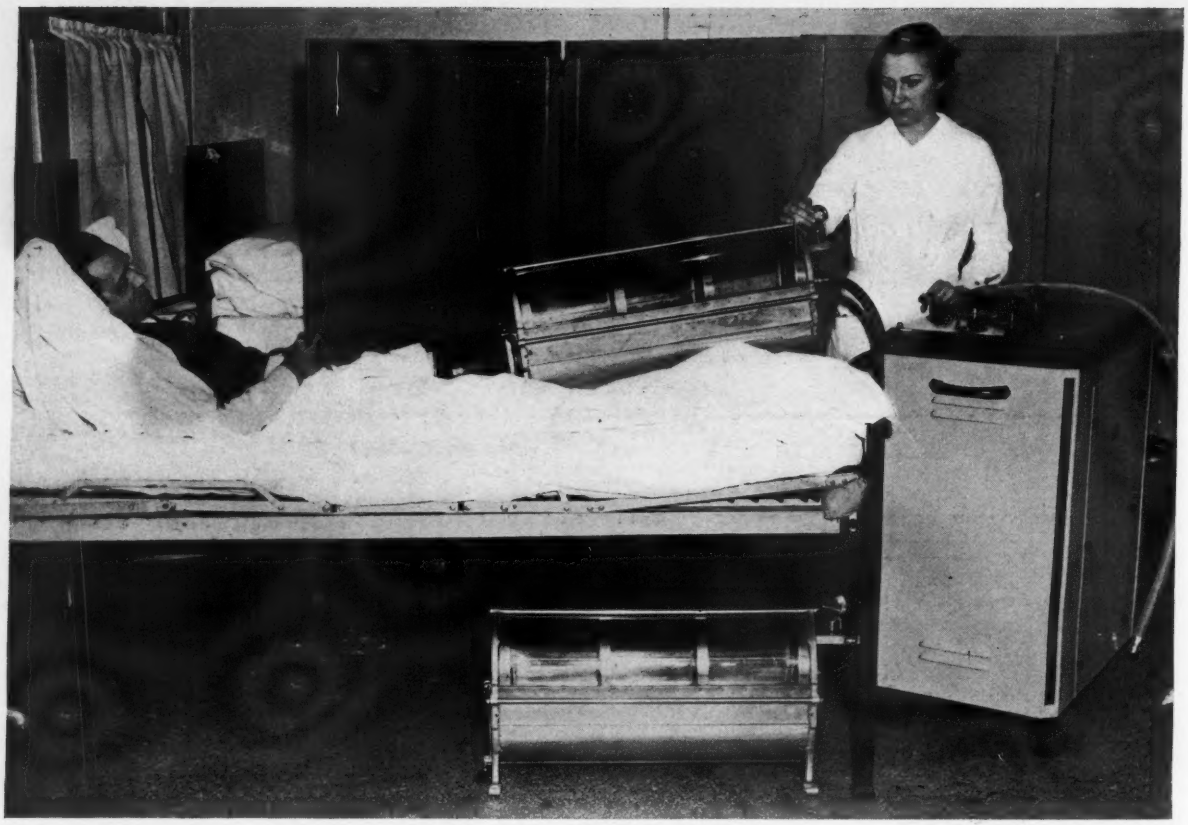
At present most of the prominent hospitals have in use one or more machines for giving pressure treatments. There are several different types on the market, called by various trade names, but the principle is the same in all and each has its good points which recommend it to the doctor and the operator. These machines range in price from $350 to $500.

The treatments are given by a graduate nurse or trained technician, always, of course, under the direct supervision of the doctor. The success of the treatment depends to a large extent upon the correct diagnosis of the case, and the knowledge of the possibilities of improvement.

The patient is placed upon a table or bed, the rubber cuffs adjusted to the leg, well above the knee, and the leg then placed in the boot. The rubber cuff must fit snugly but must not be tight enough to constrict the blood vessels. Powdering the thigh allows easier application of the cuffs. Great care must be taken of the skin of the thigh, especially in cases where intensive treatment is being given. These patients have poor circulation and consequently any abrasion of the skin must be guarded against. Gentle massage of the thigh with alcohol after a treatment keeps the skin in good condition.

There is always a slight backward and forward movement of the extremity during treatment, so the heel must be protected from friction by a pad of some kind. A rubber sponge may be used for this, or a cotton and gauze "doughnut." If the leg is very sensitive the calf may also need to be protected. There are different types of cuffs on the various machines. Some use a "sleeve" type made of soft rubber. Others use a cuff of a heavier weight rubber with an inner flange; this type is easier to apply and more comfortable in use.

The boots are generally made of glass or a heavy transparent celluloid, although some are of metal, with celluloid sections. They may be cleaned with an alcohol sponge on forceps. The glass boot may be sterilized in the Autoclave without fear of breaking. How-



The photograph above shows a nurse giving a treatment for stimulating circulation by alternating pressures.

ever, the celluloid boot is much lighter to handle and there is less danger of breakage.

During the treatment the interior of the boot often becomes clouded with a film of moisture, obscuring vision. This may be obviated by wiping out the boot with a moist cloth with a little soap on it and then polishing with a soft dry cloth. The foot should be elevated a few inches above heart level to facilitate the return of venous blood.

There is a new type machine being tried out now. It does away with the boot idea entirely, the treatments being given by means of a pneumatic cuff applied to the thigh, which is alternately inflated and released, the pressure and frequency being controlled automatically. There is also on the market now a small machine which works on this principle, but is operated by hand. It may be manipulated by the patient himself, and is priced within reach of the individual. This machine should gain in popularity as it makes treatment accessible to a great many patients who either cannot afford the number of treatments they should have, or find it impossible to make frequent trips to the hospital or doctor's office because of their condition.

A. Z. was admitted to the clinic complaining of continuous pain in the extremities, increased by walking and cold. For five months he had had pain in the ankles. The left foot was swollen with some cyanosis and was definitely colder than the right. Buergers Disease was the diagnosis. Vascular therapy treatments were started with one hour weekly on each leg. After four weeks it was increased to two hours weekly on each leg. But after a few treatments the patient asked that it be reduced to one hour again, on account of increased soreness after treatments. This was done for a few weeks and then the two hours weekly were resumed with no further complaint of soreness. Treatments were continued with gradual improvement in the patient's condition, until, after fifty hours of treatment, the patient was able to return to work.

D. P. is a man of sixty-seven, with Diabetic Arterio-Sclerosis. For three years he had had pain in the calves of both legs. When he came to the clinic he complained of intermittent pain in legs and that his feet felt dead. Vascular therapy treatments of one hour, three times a week were started. After twenty hours of treatment he was able to walk much more easily, and with forty hours there was marked improvement. Treatments were discontinued after fifty hours. Six weeks later he returned complaining that he felt a little worse again. At present he is receiving one hour a week and this enables him to be fairly active and comfortable.

While we have nothing spectacular to report, it seems to us that the success we have had in being able to return some of these patients to their work, and maintaining a fair degree of comfort for others, possibly helping them to avoid amputations, points to a definite and important place in the future for this form of therapy.

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Oxygen Therapy

By RUTH SACKETT, R.N.

» » To the lay mind an oxygen tent or any other instrument of oxygen administration is indicative of rapidly approaching death. This is due merely to the fact that over a fairly long period of time oxygen was employed only in great emergencies, usually as a final resort when the patient was felt to be beyond hope. In the last quarter of the eighteenth century, however, when oxygen first came into use as a therapeutic agent through the work of Priestly and Lavoisier, it was regarded as an almost universal panacea and was prescribed for nearly all the ailments of mankind. Then it suffered the fate of many new therapeutic agents that are used extensively without adequate knowledge and experimentation; for a time oxygen therapy fell into disfavor and had but occasional and frequently erroneous application. In the last half of the nineteenth century, the interest taken in the newly developing science of anaesthesia stimulated fresh curiosity in the part played by oxygen in normal and pathological conditions. Oxygen gained favor as a therapeutic agent, but due to inadequate research and knowledge, only doubtful results were obtained.

During the years 1910-1920 there were brilliant researches on the physiology of respiration. This new knowledge and the part that oxygen played in it, led to a clearer conception as to the use of oxygen as a therapeutic agent. During this same period the World War, with the inception of gas warfare and its resultant pulmonary complications, gave further impetus to the revival of oxygen therapy.

Practically all reputable hospitals have at present some sort of equipment whereby oxygen may be adminstered to a patient. The economic factor has hindered the more generalized acceptance and use of this form of therapy.

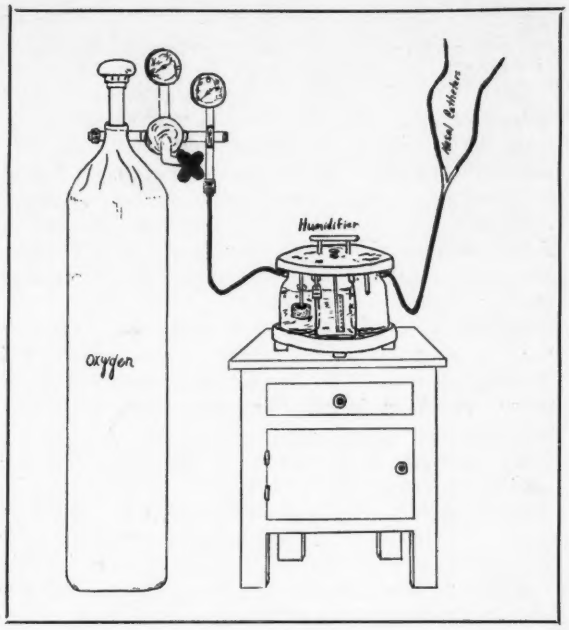
An oxygen therapy service in a modern hospital should fulfill at least four requirements, namely:

It should be scientifically and clinically efficacious; it should be readily available for a number of patients at one time; it should be simple in technic; and, it should be as economical as possible.

There are three common technics for the administration of oxygen therapeutically, namely: the tent, the mask, and the oro-pharyngeal insufflation.

In using the tent, the mattress should be covered with a rubber sheet to prevent escape of oxygen. The ice compartment is filled with ice in pieces the size of one's fist. The body heat from the average person will melt ten pounds of ice in an hour, so great care must be taken to see that the tent is well iced. The overflow pan must also be watched. Soda lime is added to the wire screen compartment and this takes care of excess carbon dioxide, exhaled by the patient. There are two gauges to be watched, one is for oxygen in circulation, and the other is for the actual oxygen content. The sum of the two gauges governs the liter flow per minute. If the temperature inside the tent is to be cooler, there must be added oxygen in circulation. The important thing to be remembered at all

Presented at the Annual Institute of the First District of the Illinois State Nurses' Association, Chicago, April 1, 1937.



times is that the sum total of both gauges equals the oxygen in liters as ordered. The patient is fed through an opening in the side of the rubber tent covering. With the tent the patient requires continuous nursing care, and he is often difficult to control due to his sense of confinement.

The mask method provides for only intermittent administration. Many patients will not tolerate even temporary cessation of the oxygen flow.

The oro-pharyngeal insufflation technic for the administration of oxygen is employed most frequently. The description of this technic as used may be divided into three sections, namely:

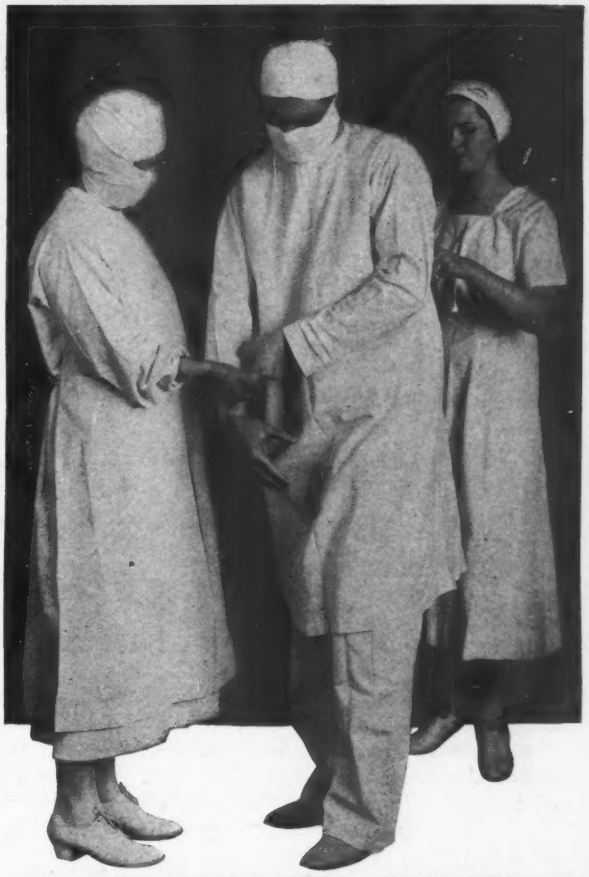
Apparatus; technic of placing the catheter; discussion of application of this technic.

Apparatus: Large supply cylinders should be used as they obviate the necessity for frequent changes. They are easily transported on two-wheeled trucks. These tanks are equipped with gauges which not only register the amount and pressure of oxygen but also estimate the flow of oxygen in liters per minute. By regulation of these gauges the desired flow from one to fifteen liters per minute may be obtained. Humidification of oxygen adds materially to the comfort of the patient, and the more simple the type of apparatus the better. In order to humidify the oxygen adequately it should be broken up into fine bubbles. The catheter selected should be small, but most important, it should allow a free flow of oxygen. It is well to test the lumen of the catheter by placing the tip in water and introducing air through it.

Large calibre rubber tubing should be used in making connections between the source of oxygen supply, thought of from the standpoint of the student, while a case study is thought of from the point of the social, psychological and economic status of the patient.

Instructions on the use of correlation sheets should humidifier and catheter. In connecting a single catheter which deals with one patient only, the correlation

(*Continued on page* 43)



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The Coordination of the Doctors' and Nurse-Supervisors' Classes

By MAY L. CROUCH, R.N.
Director, Henrotin Hospital School of Nursing, Chicago

» » We will agree, I believe, that the doctor's lecture should always precede the nursing class and that as short an interval of time as is possible should elapse between these two classes. If the student is to derive the greatest benefit from her theory and practice, there must be a close correlation of the two.

There are several methods which may be used in coordinating doctors' and nurse-supervisors' classes:

1. Nurse-supervisors' class and demonstration; 2. Case assignment; 3. Case study; 4. Bedside clinics; 5. Group conference; 6. Morning assembly; and 7. Correlation sheets.

Nurse-supervisors' class and demonstration. Let us assume that the doctor has given a lecture on "Diseases of the Heart." (It is well to submit to the doctor topics and suggested outlines for the course which he is to teach.) The nurse-supervisor emphasizes the special nursing care of the skin to prevent decubitis, the various methods of making a heart case comfortable in bed, such as the use of the gatch, back and knee rest, pillows, and the use of an ice cap. Why are these used? The nurse-supervisor or nurse-instructor will review the purpose and action of drugs used in heart disease, such as the various preparations of digitalis. What is the action of these drugs? What are the danger signs? These patients and their families need very careful directions as to their care upon discharge from the hospital. The students must be introduced to the role they are to play as teachers.

Case Assignment. Since the student is practicing her nursing in the service representing the theory she is receiving, or has received, there should be no difficulty in assigning her to a patient with heart disease. When this is done, the student is able to make application of what she has heard in the lecture room, and seen in the classroom. Case assignment enables the student to see the patient as a whole, not just one phase of his illness; it encourages and develops powers of observation which are most essential.

Case Study. A case study is a detailed study of one patient, and aids the student in gaining an understanding of this patient. It should give her an awareness of the patient as an individual and as a member of his community. A case study includes the social, psychological and economic environment of a patient. The student acquires a more intimate knowledge of nursing problems, appreciates more fully the part heredity and environment may play in the production of disease and the part public health nursing might have played in prevention, and may play in recovery.

Care should be taken in the selection of a case; choose one which best illustrates the principles underlying the care of a particular type of condition. Patients with uncertain diagnosis are not the most desirable for case studies. Those in which the symptoms and unusual type of treatment are to be desired. Above all remember that a student will receive more benefit from her case study if the patient she is studying is assigned to her for care.

Bedside Clinics. The bedside clinic will draw for the student a composite picture of the medical and nursing aspects. The nurse-supervisor should use every precaution in selecting those cases which best illustrate the material being presented.

To illustrate: in patients suffering from heart disease the nurse-supervisor can show the actual variations in pulse and respirations which were discussed in the doctors' lecture. The nursing procedures for making the patient comfortable may be demonstrated.

After the student has made her observation, the patient should be returned to his room. Now, in the absence of the patient, the students and instructor may enter into a free discussion of this patient's condition. In holding a bedside clinic, the nurse-supervisor should emphasize the need for carefully guarding the conversation which occurs in front of a patient.

Group Conference. A conference is based upon the supposition that everyone has something of real value to contribute. A group conference should be held, for about one hour, at a time of day when the ward is quietest, to allow those participating a feeling that there is time for discussion. An informal gathering probably promotes more freedom of discussion. In those cases where they can contribute to the conference, the doctor, social worker, dietitian, occupational and physio-therapists should be invited to attend.

Morning Assembly. Morning assembly teaches the student while she is on the ward. It is a kind of clinic held for all students in that particular unit, but no patient is present. The success of morning assembly is due to the fact that nothing interferes; the day's work has not yet begun. Morning assembly should be held immediately following the night report and should consume not more than fifteen or twenty minutes. If more time is taken the students become restless from standing too long.

Each morning of the week, except Sunday, some phase of the doctors' lecture or nurse-supervisors' class may be discussed, such as etiology, pathology, medication or some nursing treatment of a specific case.

Assignments for morning assembly can usually be made several days in advance. A different student should be assigned each day, but all should take part.

There are several advantages to this method:

1. Students are usually wide awake; 2. There is no interruption by classes; 3. It is practically the only time of day most students can attend; and 4. An alert, interested frame of mind is introduced before actual work begins.

Correlation Sheets. In contrast with the case study,

sheet is a general study of several patients. It is be clear and concise. For example, students should be instructed to use cases observed as well as those cared for, and to select one case of each type which gives typical symptoms. Material may be taken from charts and from direct observation.

All of these methods are valuable in coordinating the doctors' and nurse-supervisors' classes. Some give the student a more vivid picture than others. In our experience, the case assignment and case study have proved to be the most satisfactory.

Oxygen Therapy . . .

(*Continued from page* 41)

to rubber tubing use ordinary glass connection, but if there are to be two catheters, a glass Y-tube is the means of connecting catheters to tubing.

Technic of Placing Catheter: The efficiency of this technic is entirely dependent upon proper placement of the catheter in the oro-pharynx. The catheter is lubricated with vaseline. Light oils and jellies tend to leave the catheter dry. Measure the distance of the catheter to be inserted at four and one-half to five and one-half inches, or at a distance from nares to tragus of ear. The oxygen is turned on and with it flowing at the rate of five to six liters a minute, the catheter is carefully introduced into the nares beyond the measured depth until the patient is seen to swallow a bolus of oxygen. The catheter is then withdrawn to the point where swallowing is no longer observed. When the correct position has been found the catheter is firmly fastened to the nares and cheek with adhesive tape.

With the flow at four liters per minute, actual alveolar samples contained 29.1% to 43.6% oxygen, and with the flow at eight liters concentrations were obtained from 60% to 70%. The removal of the catheter and its replacement by a clean one should be governed by the amount of mucous secretion of the patient and his comfort. A clean one should be inserted in the opposite nostril at least once every 12 to 24 hours. If irritation is present, the frequent installation of oil is helpful.

Discussion of application of this technic: When therapy is first instituted a high concentration should be used, 6 to 10 liters per minute according to the patient's needs, and strictly according to the attending doctor's orders. The pulse rate should be observed and recorded every fifteen minutes, and usually with this high concentration the rate will be reduced in the course of a few hours. The concentration is gradually reduced according to the condition of the patient, and the patient is gradually weaned from oxygen therapy. The nurse must be fully acquainted with oxygen administration and it should be a nursing procedure.

Equipment costs of various technics are easily compared. Equipment for oro-pharyngeal method is by far the most economical, as it requires no extra nursing or technical supervision for administration.

Acknowledgments: "Oxygen Therapy at Wise General Hospital," *Hospitals*, March, 1936; Oxygen Therapy," Wm. Thalhimer, M.D., *American College of Surgeons Bulletin*, Dec., 1932; "Oxygen Therapy," W. M. Boothby, M. D., *Journal A.M.A.*, Dec. 10, 1932.

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THE NEW PARTNER IN THE BUSINESS

By MARY W. NORTHROP
Chief Dietitian and Housekeeper, King County Hospital System, Seattle

» » » SOME SMALL HOSPITALS still maintain that they do not need a dietitian or that they cannot afford one or that they have not enough work for a dietitian to keep her busy. As a matter of fact, the food is as important in a small hospital as in a large one—more important, perhaps, since the small hospital is more dependent on the satisfaction of each patient—and a good dietitian can usually improve the food. The small hospital cannot afford to be without a dietitian. Running on a close margin, it needs the benefit of the economies she knows how to make. The small hospital can keep a dietitian busy, so busy, indeed, that if she is to use her time to the best advantage of the hospital she must have some clerical assistance to relieve her of routine. As a matter of fact, standards in the best large general hospitals now call for a ratio of a dietitian to every fifty patients.

The present trend is to combine the dietary and housekeeping departments under one head. The dietitian is the one person trained for both housekeeping and hospitals. The hotel housekeeper does not understand hospital situations. The nurse is not a trained housekeeper. The well-meaning but untrained woman whom we have seen as housekeeper in hospitals in the past knows neither field, and has had neither training nor experience in personnel scheduling and management. The dietitian, in her undergraduate work in home economics, is taught the theory of institution management. In her graduate year as a student dietitian in a hospital she learns hospital problems and routines. Several of the approved courses for student dietitians assign her a regular rotation in the housekeeping department. In a hospital of less than fifty beds, one person with some clerical assistance can manage both departments. In a hospital of more than fifty and less than a hundred beds, a mature dietitian can very well be the head of both departments if she has a well trained young assistant. This provides for trained professional supervision of the entire related problem of the household, and would pay in satisfaction even at an increased cost. As a matter of fact, it does not cost more.

Given an adequate department head, the superintendent will find that he secures the best results by treating her like a partner in the business, not like an employee who works for a wage and has no interest in the progress of its affairs. Made to feel that the department is hers to develop, she will give her originality and initiative their full scope. The dietitian is head of one of the major departments in the hospital. As such, she needs prestige, which the superintendent must help her to build. Only if she has the superintendent's confidence can she gain and hold the confidence of the house. He must bring her out of the far corner of the basement where her desk has been tucked, and establish her in a suitable office on the administrative corridor. One of her major purposes is to be available to doctors to talk over the problems that arise in feeding their patients, and doctors are busy men who will not go exploring in basements.

The province of the dietitian should start with the formulation of the budget and should include every step in the food service process from the market to the patient—or rather, to the garbage can, since there lie the profits of many an institution. She should be expected, on the one hand, to be the business-like head of a business department, keeping in close balance the problems of quality and cost, and on the other hand to be a member of the professional personnel engaged in the care of patients. She is held responsible for the quality of the service given by her department and for keeping within the budget. She must therefore control the purchasing, preparation, and service of the food. Employees must recognize her as their chief, and all contacts between the administration and the employees must go through her hands. She must have authority where she has responsibility.

With tray service in the hands of the dietitian, it is

(*Continued on page* 51)

Presented at the Sectional Meeting of the American College of Surgeons, Seattle, Wash., March 31, April 1 and 2, 1937.

A GUIDE TO BUYING AND COOKING FISH

By W. MARCEL SHAW
Technician de Cuisine, St. Margaret's Hospital, Hammond, Ind.

» » » FISH as a source of nourishment is far less satisfying and stimulating than meat, although some of the red-fleshed fish are almost as nutritious as meat.

The white-fleshed fish, such as whiting, sole, haddock, hake and cod, are less nourishing but much more digestible. Cod and hake are remarkably firm-fleshed and fibrous and even when in good condition are difficult to digest. The flesh of these fish contains little or no fat. In other fish, with the flesh "off" white, there will be found grains of fat through the tissues. Herring, porgie, pompano, lingcod, eels, and mackerel are very rich, supplying much nourishment and a delicate blend of fat and flavor.

In choosing fish, the first requirement, of course, is that it be fresh. Stiffness and rigidity of the flesh is a sure guide, for as rigor mortis passes off the flesh loses its firmness and becomes loose and flabby. Smell is not a sure guide as, if the fish has been kept on ice, it may smell fresh and then change after it has been removed from the ice. The redness of the gills is always a good indication of freshness; also the brightness of the eyes, which should not be sunken too far into the head. The scales should be firmly intact and if the fish is only partly covered it is either stale or damaged—in either case, it will not keep.

The skin of the fat fish should be smooth, pliant and moist. Large fish such as salmon and cod should have a bronze tint when freshly sliced. Very large fish, as a rule, are not to be preferred, as the flesh may be very "grainy" and strong.

The accompanying table is an excellent guide in regard to buying, type, season, and the best method for cooking. Next in importance to freshness is the seasons for each variety as the quality of the fish is influenced by the act of spawning and presents considerable variation. Just previous to the spawning period, fish approach a state of edible perfection as they are then fatter and of a rich delicate flavor. During and after the spawning period the store of fat has been largely depleted and the flesh becomes thin, watery and "flat" in flavor. It is then that the different varieties are considered "out of season."

Methods for Cooking

Broiling. Clean and split fish or use fillets or steaks. Season liberally with salt and white pepper. Rub with melted butter or a bland cooking oil. Place under hot flame until surface is seared, gradually lowering fish from flame; turn as is indicated and cook until tender. (For fillets, 12 to 15 minutes.) If seasonings are desired, such as onions, bacon, butter, etc., they should be applied while fish is broiling.

Boiling. Either whole fish, fillets, steaks or portions may be used as desired. Wrap fish in cheese cloth or parchment paper and boil gently in water to which has been added one teaspoon salt, one tablespoon vinegar or lemon juice (to keep flesh firm), an onion, one bay leaf, one clove (to each two quarts of water). About 22 minutes is required to boil a four-pound fish. Remove wrappings carefully.

Serve with white sauce to which chopped egg, pickles, chives and parsley have been added. Broiled grapefruit sections make an attractive and appetizing garnish. (To broil grapefruit sections: dust generously with powdered sugar, place under "quick" broiler until golden brown.)

Steaming. Proceed as for boiling except that fish is kept on a rack above the boiling liquid. This method requires about double the time needed for boiling.

Egg and Crumbs, or Cornmeal Method. Roll fish in bread crumbs, flour or cornmeal. Cover completely, then dip into beaten egg mixture, roll again in crumbs. When fried in deep fat this produces a crusty, golden coating, protecting the fish from the direct contact with the hot fat.

Deep Fat Frying. Have fat approximately 360° to 390° F. or test with cube of bread, which should be crisp and golden brown in from 50 to 60 counts. Do not crowd as this lowers the temperature of fat, causing the fish to become moist and soggy. When fish is golden brown, cooking is completed. Lift from fat, allow to drain, and serve immediately.

Pan Frying or Sautéing. This method of cooking requires very little fat or oil. Fish must be turned as cooked. (Handle carefully.) Crumb method may or may not be used, although a light dusting of corn meal or bread crumbs will prevent breaking. Steaks or fillets about ⅝ inches thick are preferred.

Portions of Fish

Fillets are the meaty sides which are cut from the fish immediately after they are caught. Fillets are marketed either skinless or with skins on. Fish skin is a delightfully edible food composed mainly of gelatine of the highest quality. Fillets may be bought fresh, frozen or smoked and are most economical to use as there is no waste.

Steaks are cut from the larger unboned fish. The slices are cut cross-wise and are ready for immediate use.

Frozen fish are "fresh" fish with all their wholesomeness and fine flavor preserved for "out of season" use. The same methods of cooking may be applied to frozen as to fresh fish. Frozen fillets, steaks and small fish need not be thawed before cooking but this is necessary with larger fish. Thawing should be done slowly, in a refrigerator or on melting ice.

Bouillabaisse

(25 portions)

8 quarts of water or white stock
2 pounds fresh shrimp
1½ pounds scallops
5 pounds fillets of any boned fish
2 pounds lobster meat
2 quarts oysters
4 large onions, diced
2 cloves garlic finely chopped
2 tablespoons curry powder
1 quart tomato soup
8 ounces grated American cheese
1 pint sherry wine
4 bay leaves or 1 teaspoon cloves
2 pounds fresh mushrooms
6 ounces butter
salt and pepper

Boil shrimp and cloves in sufficient salted water, then remove shrimps with straining spoon, retaining the water, as this is to be used later. Remove shells from the shrimps and slit them in halves, lengthwise. Slice mushrooms about ¼ inch thick and allow to stand with shrimp until needed. Dice the onions and garlic. Put butter in frying pan (olive oil may be used). When melted, sauté onions and garlic until golden brown; then add tomato soup, curry powder, bay leaves, cloves, grated cheese, wine and allow the mixture to simmer ½ to ¾ of an hour.

Bring the water in which the shrimps were cooked to a boil, then add the fillets of fish, scallops, cloves, one cup sherry wine and allow to simmer gently until fish is tender, (do not allow to boil as the fish will break). Now, add the shrimps and mushrooms to the sauted mixture and simmer together 5 minutes; thicken slightly with flour.

To serve, strain water from the fish, place on serving dish or platter, remove bay leaves from the sautéd mixture, and pour over fish and serve.

L'Espagnole Courthoullillon

12 pounds red fish or red snapper
1 cup cooking oil
¾ cup flour
4 onions (large)
24 tomatoes (fresh)
¼ cup parsley; 3 cloves garlic
½ teaspoon thyme
4 sprigs sweet basil; 6 bay leaves
1 pint white wine (dry); 1 gallon water

Make a roux of the cooking oil and flour. Add onions, chopped tomatoes, parsley, garlic, sweet basil and thyme (all chopped very fine). Add the bay leaves whole. When nicely brown, pour in clear stock or water and allow to come to a boil. Rub fish well with salt and pepper and pour over it a cup of boiling white wine. Allow to simmer gently until fish begins to soften. Then remove from fire, lay slices on serving dish or platter. Remove bay leaves from sauce and pour over the fish and serve. Broiled pineapple slices to garnish.

Vegetable Shrimp Salad

1 quart shrimp
1 pint diced celery
10 hard boiled eggs
1 cup peas
1 cup corn niblets
1 cup shredded green peppers
½ cup diced pickled beets
1 tablespoon each of finely chopped parsley and chives

Mix all the above together lightly with mayonnaise, season with salt and white pepper. A little lemon juice may be added if so desired.

An Ideal Supper Casserole

15 pounds fish, halibut (cooked)
5 pounds macaroni (cooked)
1 pound grated cheese (sharp)
4 ounces butter, white pepper and salt
1 lemon (juice)
2 cups finely chopped green onions

Species	Lean or Fat	Broil	Bake	Steam or Boil	Chowder	Seasons
Allwives	Fat	(*)	...	(*)	...	Jan.-June
Barracuda	Fat	(*)	(*)	(*)	...	Feb.-June
Bluefish	Lean	(*)	(*)	...	...	a 11 year
Blue pike (Jack Salmon)	Lean	...	...	(*)	...	Mar.-Dec.
Blue runner	Fat	(*)	(*)	...	...	Nov.-Apr.
Buffalo Fish	Fat	(*)	(*)	...	...	Sept.-May
Butter Fish	Fat	(*)	...	...	...	Apr.-Dec.
Carp	Lean	(*)	(*)	(*)	...	All year
Cat Fish	Lean	...	...	(*)	(*)	All year
Chubs	Fat	(*)	...	...	...	All year
Cisco (lake herring)	Fat	(*)	...	...	...	Mar.-Dec.
Cod	Lean	(*)	(*)	(*)	(*)	All year
Crappie	Lean	(*)	...	...	...	All year
Croaker (Hard head)	Lean	(*)	(*)	(*)	(*)	All year
Cusk	Lean	(*)	(*)	(*)	(*)	All year
Drum, red (Redfish (Channel bass)	Lean	...	(*)	(*)	(*)	Nov.-June
Eel	Fat	...	(*)	(*)	...	All year
Flounders	Lean	(*)	(*)	(*)	(*)	All year
Groupers	Lean	(*)	(*)	(*)	(*)	Nov.-May
Haddock	Lean	(*)	(*)	(*)	(*)	All year
Hake	Lean	...	(*)	(*)	(*)	All year
Halibut (with fat trimmed out)	Lean	(*)	(*)	(*)	(*)	All year
Herring (Lake)	Lean	(*)	(*)	...	...	All year
Herring (Sea)	Fat	(*)	(*)	...	...	All year
Kingfish	Lean	(*)	(*)	(*)	(*)	Jan.-June
King Whiting	Lean	(*)	...	(*)	(*)	All year
Lake trout	Fat	(*)	(*)	...	...	Apr.-Nov.
Lingcod	Fat	(*)	(*)	(*)	...	All year
Mackerel, Boston	Fat	(*)	(*)	...	...	May-Nov.
Mackerel, Spanish	Fat	(*)	(*)	...	...	Nov.-May
Mackerel, California	Fat	(*)	(*)	...	...	All year

Species	Lean or Fat	Broil	Bake	Steam or Boil	Chowder	Seasons
Mullet (popeye)	Lean	(*)	(*)	(*)	(*)	All year
Pilchard (Sardine)	Fat	(*)	...	...	...	Aug.-Mar.
Pike—pickerel	Lean	(*)	(*)	...	...	All year
Pollack	Lean	(*)	(*)	(*)	(*)	All year
Pompano	Fat	(*)	(*)	(*)	...	All year
Porgie	Fat	(*)	(*)	...	...	All year
Red snapper	Lean	(*)	(*)	(*)	(*)	All year
Sablefish	Fat	(*)	(*)	(*)	...	All year
Salmon	Fat	(*)	(*)	(*)	...	All year
Seup	Fat	(*)	(*)	...	...	Jan.-Nov.
Sea Bass (black fish)	Lean	(*)	(*)	(*)	(*)	All year
Shad	Fat	(*)	(*)	...	...	Dec.-July
Sheepshead (river drum) gaspergon	Lean	(*)	(*)	(*)	(*)	All year
Smelt	Fat	(*)	...	...	...	Sept.-May
Sole	Lean	(*)	(*)	(*)	(*)	Oct.-Aug.
Spot (Cape Cod Goodie)	Lean	(*)	...	...	...	June-Nov.
Spotted Trout	Lean	(*)	(*)	(*)	(*)	All year
Striped Bass (rock)	Fat	(*)	(*)	...	...	All year
Sturgeon	Fat	(*)	(*)	...	...	Mar.-Jan.
Sucker	Lean	(*)	(*)	...	...	Dec.-June
Sunfish	Lean	(*)	...	...	...	Apr.-Nov.
Swordfish	Lean	(*)	(*)	...	...	June-Oct.
Weakfish (gray trout, sea trout)	Lean	(*)	(*)	...	...	Apr.-Nov.
White Bass	Lean	(*)	(*)	...	...	All year
White fish	Fat	(*)	(*)	...	...	Apr.-Dec.
Whiting (Silver Lake)	Lean	(*)	(*)	(*)	(*)	May-Dec.
Wolffish (Ocean Catfish)	Lean	(*)	(*)	(*)	(*)	Oct.-May
Yellow Perch	Lean	(*)	(*)	...	...	All year
Yellow Pike	Lean	(*)	(*)	...	...	All year
Yellow Tail	Fat	(*)	(*)	...	...	All year

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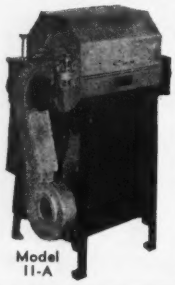
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HOSPITAL MANAGEMENT
612 No. Michigan Ave. Chicago, Ill.

Remove all skin and bone from fish and separate into large flakes. Fill well oiled baking dishes with alternate layers of seasoned fish and macaroni and top with butter. Bake 20 minutes. Sprinkle top with finely chopped onions and parsley that has been previously marinated in lemon juice.

Sauces most generally used with fish are given herewith:

White Fish Sauce

½ pound butter or substitute
2 gallons heated milk
1¼ pound white flour
1 bay leaf
2 blades of mace
2 lemons (juice)
Salt and pepper to taste
Bones and trimmings from fish

Heat butter in saucepan until it bubbles. Then gradually stir in flour mixed with seasonings, stirring the mixture with a spoon until the whole is blended. Add fish bones, spices and trimmings. Gradually add heated milk, stirring until the whole is smooth. Cook slowly one hour, strain, serve hot.

Shrimp Sauce

1 pint shrimps (fresh)
1 quart white fish sauce
2 tablespoons of anchovy essence
½ cup vinegar
3 blades mace; 2 bay leaves
1 cup grapefruit juice

Place shrimps in pot; add vinegar, mace, bay leaf, and boil slowly for thirty minutes. Strain liquor through cheese cloth and incorporate into white fish sauce. Clean shrimps and add to the above; allow to boil slowly five minutes. Before serving, add anchovy essence, salt and pepper to taste. Serve with boiled or grilled fish.

White Wine Sauce (Sauce Vin Blanc)

1 gallon white stock
1 pint of sauterne or Angelica wine
8 ounces butter
5 ounces flour
16 egg yolks
2 lemons (juice)
1 pint fish stock

Melt five ounces of the butter in saucepan, stir in flour, add fish stock, white stock, wine and cook slowly for 20 minutes. Add gradually the balance of the butter in small pieces, also the yolks of the eggs one at a time. Season with salt and white pepper, and whip in the lemon juice. Strain through cloth. Care must be exercised in making this sauce to carefully follow these directions. Serve with whiting, trout, sole and salmon.

Creole Sauce

1 pint minced onions
1 quart minced sweet peppers
2 quarts tomatoes
8 ounces melted butter
1 small minced garlic clove
1 teaspoon salt; 1 teaspoon pepper (scant)
2 tablespoons paprika

Place butter, onions, garlic and pepper in saucepan: simmer for ten minutes or until tender. Add tomatoes and seasonings, and boil for five minutes. Serve hot. The clear meat of various kinds of seafood, cut in small slices, may be boiled in this sauce for about ten minutes and served as a whole.

Horse Radish Sauce

1 pound finely chopped onion
9 ounces butter
1 pint egg yolks
1 gallon cream, milk or soup stock
1 quart freshly grated horseradish

Melt butter and sauté onions until done. Add cream or milk and cook for several minutes. Strain through a fine sieve and mix with well-beaten egg yolks. Place in double

boiler and cook until thick, stirring constantly. Add horseradish. Serve with either fish or meat.

Xavier Sauce

3 bunches water cress
a few sprigs of finnel
2 quarts milk
fish bones, and fish essence
6 ounces of butter
4 ounces of flour
lemon juice

Remove stalks from cress and finnel, put leaves in stew pan with the milk and fish bones (cut). Boil until leaves are tender. Strain and allow to cool. Pour the cooked herbs in a mortar with half of the butter, then rub through a sieve. Make a roux with the balance of the butter and flour; dilute with the milk in which the cress and finnel have been boiled. Stir until it thickens, add the fish essence and allow to cook for ten minutes. Strain, return to fire, add the green puree and cook for a few minutes. Season with the lemon juice, salt and pepper. Add cream or stock if too thick.

Hollandaise Sauce

16 egg yolks
1 pound butter
1 cup water
1 cup tarragon vinegar
4 tablespoons flour
2 lemons (juice); salt and white pepper

Mix butter to a soft consistency. Add flour and cream thoroughly. Add vinegar and water, mix well, place in saucepan and cook slowly a few minutes. Then add the beaten yolks; whip until mixture thickens but do not allow to boil. When ready to be used, add lemon juice. Freshly chopped spinach puree (drained) may be added to this sauce for flavor and color. Keep warm in bain marie.

Tomato Sauce

2 gallons beef stock
10 ounces of lean bacon
7 ounces flour
2 ham bones and skin
10 ounces butter
2 No. 10 cans tomato puree
10 ounces celery roots or trimmings
¼ ounce aragana
Boquet garni: peppercorns, sweet herbs, parsley

Sauté bacon, medium done, add onions and celery trimmings. Drain off surplus fat, add butter. When butter is melted, make a roux with the flour. Stir hot tomato puree, cook slowly. Place all in covered pot and cook in compartment steamer two hours. Strain and work in one cup sugar, one cup olive oil, salt and pepper to taste.

Maitre d'Hotel Butter

This is a cold dressing often served with boiled or fried fish.

1 pound butter (solid), sweet
1 teaspoon minced parsley
2 lemons (juice)
salt and pepper to taste

Cream the butter, gradually working in the lemon juice, salt and pepper. When well blended, work in the parsley and with butter paddles, roll into balls about ¾ inch in diameter. Chill and place one butter ball at the side of each serving of fish. Sprinkle lightly with salt.

Lemon Butter

1 pound butter melted
3 lemons (juice); ½ teaspoon white pepper

Blend all together thoroughly; serve hot. To be used especially on broiled, baked or planked fish.

Tartar Sauce

1 gallon mayonnaise
1 pint minced pickles (sour)
1 tablespoon minced parsley
1 tablespoon minced capers
2 tablespoons minced chives

Season to taste. Mix thoroughly. Serve cold. This is best served with deep fried fish, oysters, etc.

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Day	Breakfast	Dinner	Supper
1.	Tomato Juice; Whole Bran Omelet; Jelly	Roast Beef; Browned Potatoes; New Peas Head Lettuce; Pineapple Rice	Meat Pie; Green Beans; Cole Slaw Fresh Fruit
2.	Baked Apple; Rice Bacon; Toast	Liver Loaf; Creamed Carrots Potato Salad; Sliced Oranges	Vegetable Plate; Hot Rolls Cheese Salad; Canned Pears
3.	Stewed Apricots; Oatmeal Cottage Cheese	Swiss Steak; Baked Potato Mixed Vegetable Salad; Brown Betty	Vegetable Chowder; Corn Bread Strawberry Whip
4.	Grapefruit French Toast; Bacon	Baked Fish; Egg Sauce; Parsley Potatoes Cole Slaw; Lemon Ice Cream	Baked Pepper; Steamed Rice Apple Salad; Chocolate Pudding
5.	Orange Juice Wheaties; Egg on Toast	Spaghetti; Tomato Sauce Fish Salad; Apricot Snow	Boiled Tongue; Spinach Potato Salad; Berry Cobbler
6.	Pineapple and Bananas Breakfast Ham; Toast; Jam	Country Fried Chicken; Mashed Potatoes Peas; Perfection Salad; Ice Cream	Chicken Sandwich; Garden Salad Fresh Fruit; Cake
7.	Spiced Apple Sauce Bran Flakes; Egg Plant	Pot Roast; Mixed Vegetables Pimiento Cole Slaw; Prune Whip	Cheese Fondue; Creamed Potatoes Endive Salad; Crumb Pie
8.	Pears Grits; Bacon; Jelly	Baked Hash; Lima Beans; Lettuce Salad Bananas; Custard Sauce	Macaroni; Tomatoes; Beet Salad Fresh Fruit; Cake
9.	Sliced Oranges; Oatmeal Poached Egg; Toast	Meat Rolls; Harvard Beets; Potato Balls Shredded Lettuce; Berry Blanc Mange	Baked Noodles and Pork Buttered Peas; Pineapple
10.	Red Cherries Creamed Corned Beef; Toast	Ham Omelet; Swiss Chard Stewed Tomatoes; Danish Rice Pudding	Corn and Sausage; Combination Salad Loganberry Ice
11.	Tomato Juice French Pancakes; Bacon	Salmon Mornay; Mushrooms Stuffed Tomato Salad; Lemon Cream Pie	Eggs, Creole; Asparagus Salad Apricot Pudding
12.	Strawberries; Oatmeal Scrambled Eggs and Brains	Italian Spaghetti; Fresh Pineapple Salad Rhubarb Whip	Bean Loaf; Celery and Cabbage Salad Blue Plums
13.	Grape Juice Cornflakes; Creamed Sausage	Baked Veal Chops; Mashed Potato Celery and Peas; Pear Salad; Ice Cream; Cake	Creamed Meat; Vegetable Salad Macaroon Pudding
14.	Orange Toast Bacon; Cocoa	Potato and Ham Casserole; Fruit Fritters Green Beans; Cabbage Salad; Mocha Pudding	Lamb Patties; Mashed Carrots Lettuce; Pears
15.	Sliced Peaches Rice; Eggs in Croustades	Veal Stew; Vegetables; Wilted Lettuce Cherry Tart	Spinach Souffle; Creamed Potatoes Blueberries
16.	Fresh Pears Bacon and Eggs; Rolls	Roast Lamb; Peas; Sweet Potatoes Tomato Salad; Apple Crisp	Macaroni and Meat; Asparagus Salad Orange Nut Whip
17.	Orange Honey Cocktail Cracked Wheat; Cottage Cheese	Beef Heart; Baked Potato Grapefruit Salad; Caramel Pudding	Vegetable Omelet; Shrimp Sauce Endive; Peach Tapioca
18.	Tomato Juice; Egg Timbale Muffins; Jelly	Broiled Fish; Egg Sauce Parsley Potatoes; Peas; Strawberries	Creamed Fish; Toast; Southern Slaw Lemon Rice
19.	Minted Pineapple Creamed Meat Balls; Bran Muffins	Liver and Bacon; Grits; Spinach Asparagus Salad; Cinnamon Apple	Potato Pancakes; Shrimp Salad Chocolate Junket
20.	Mixed Fruit Juice Cereal Flakes; Bacon	Chicken and Dumplings; Green Beans Celery and Lettuce Salad Chocolate Cream and Strawberries	Scalloped Deviled Eggs; Tomato Salad Grapefruit
21.	Blue Plums Oatmeal; Jelly Omelet	Pork Roast; Browned Potatoes; Apple Sauce Cabbage; Tomato Aspic; Bread Pudding	Scalloped Celery; Cottage Cheese Salad; Ambrosia
22.	Tomato Juice Hominy Grits; Bacon	Meat Loaf; Mashed Potatoes; Cauliflower Carrot Salad; Prune Whip	Kidney Stew; Rice; Cole Slaw Fruit Compote
23.	Figs Wheatena; Shirred Eggs	Lamb Chops; Mint Sauce; Scalloped Potatoes Asparagus; Raspberries	Baked Lima Beans and Bacon Creamed Celery Slaw; Fruit Gelatine
24.	Strawberries French Toast; Bacon	Vegetable Meat Balls; Creamed Potatoes Endive; Cherry Custard Pudding	Spanish Eggs Head Lettuce; Jelly Cake
25.	Grapefruit Corn Fritters; Sausage	Baked Haddock; Wilted Lettuce Vegetables in Lemon Butter; Apricots	Jellied Fish; Potato Salad Lemon Cream Cake
26.	Rhubarb and Strawberries Rice; Creamed Eggs	Corned Beef Hash; Cabbage Apple and Nut Salad; Sweet Potato Pie	Lamb Stew; Vegetables Escarole Salad; Blueberry Cobbler
27.	Cantaloupe; Dried Beef Toast; Orange Nut Biscuits	Baked Ham; Candied Yams; Green Beans Beet Salad; Pineapple Coconut Whip	Macaroni Salad; Cold Cuts Celery; Strawberries
28.	Tomato Juice Oatmeal; Coddled Eggs	Lamb Roast; Potato Salad Okra, Tomato and Celery; Orange Coconut Cake	Cold Salmon; Lemon; Spinach Fruit Salad
29.	Blueberries Bran; Bacon	Baked Sausage, Creole; Parsley Potatoes Prune and Cheese Salad Ginger Bread; Whipped Cream	Vegetable Plate Cottage Cheese; Caramel Apple
30.	Minted Pears Cornflakes; Jelly Omelet	Scalloped Meat; Mashed Potatoes Combination Salad; Pineapple Rice	Creamed Chicken; Peas Slaw; Frozen Cheese

The New Partner . . .

(*Continued from page 45*)

easy for the small hospital to "go modern" by offering its patients a selective menu. Patients appreciate the privilege of making a choice of foods. The menu need not be elaborate. Even the opportunity to choose brown or white bread and to state a preference in beverages, to substitute eggs or broth for the meat served, will bring favorable comments. It is easy enough for the cook to make a few custards as an alternative to the regular dessert, or fruit may be used for this purpose. The results more than justify the effort, for satisfied patients bring a direct return in increased census as well as in a larger percentage of recoveries.

Now that hospitals have spent millions of dollars in equipping special diet kitchens, it has become fashionable to close them. With tray service in the hands of a dietitian and the kitchen carefully supervised, all but the most elaborate weighed diets can be served from the main kitchen. Hotels do not operate a second kitchen because some of the guests wish a deviation from the regular menu. The new method means better food for special diet patients, simpler and therefore less costly operation, better education for student nurses.

Most small hospital dietary departments keep inadequate administrative records. Such records should include purchase records in such form that at a moment's notice full information is available about any past purchase, food cost records reduced to a per capita basis more often than once a month, inventories of equipment and supplies, and the records of the department personnel. There should be a recipe file to which additions are constantly made. Even in a small hospital, more meals are served daily than in many restaurants and tea rooms, and the restaurant which does not organize on a businesslike basis soon fails. Where there is no dietitian, of course, nobody would use and interpret the records anyway, so they would be of little value. In the hospital which has a dietitian, the protest is made that she has no time for so much clerical work. A very proper protest, for she should not spend her time that way. An hour or two a day of the time of some clerk in the business office should be assigned to her use.

The small hospital offers its dietitian a service which is difficult because of the variety of its duties, and it cannot do with a mediocre person. The size and type of the hospital will determine the amount of experience needed by the dietitian. There are a few of our young graduates of exceptional ability whom we consider ready to undertake the responsibility of the dietary and housekeeping departments of a small hospital immediately after the completion of the student course. They have then had five years of professional education. The majority of them, we feel, should hold one position as an assistant, and then come to you after one or two years of experience.

What salary does the small hospital offer these young women? You are "penny wise and pound foolish" if you try to cut the salary offered the dietitian to the point where you cannot attract competent peo-

(*Continued on page 57*)

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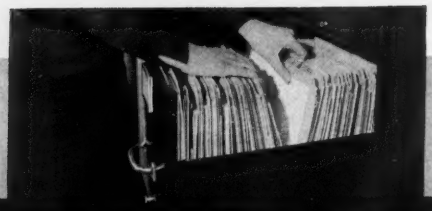

MEDICAL RECORDS DEPARTMENT

EDNA K. HUFFMAN
Medical Records Librarian, St. Joseph's Hospital, Chicago
Editor

HISTORY OF MEDICAL RECORDS

By EDNA K. HUFFMAN, R.R.L.
Medical Records Librarian, St. Joseph Hospital, Chicago, Ill.

» » » MEDICAL RECORDS have come down to us from the earliest ages, and although they were in a primitive form, very different from those in use in the hospitals of today, they were nevertheless a form of medical record, and served the same purpose as ours serve us today, whether they were carvings on the hillsides, graven plates, potsherds, tracings burned into the clay tablets of Nineveh and Babylon, heiroglyphics on the papyri, tombs and walls of Egypt, or lettering on the parchment rolls of Rome. These early records in whatever form or medium they were preserved, were the basis for the early medical manuscripts, and just as today the literature is derived from the original medical records, so in that time two thousand years ago the manuscripts originated from the medical record.

Thot, an Egyptian, may well be considered the father of medical records librarians, because about 4500 B.C. he wrote thirty-six books, six of these being of a medical nature, and this seems to be the earliest authentic date at which recordings of the care and treatment given patients have been found.

Operative records have been found dating as early as 3000 B.C., and were also found in Egypt. The Edwin Smith Papyrus, the oldest of the six Egyptian papyri, deals with surgical subjects, and is in a sense a form of operative report, having recorded among other procedures, "suture to approximate wound edges." About 2500 B.C. picture writing on the tomb of Saqquarah also referred to surgical procedures, while in 2250 B.C. Hammurabi, a Babylonian king, promulgated a code dealing with both medical and surgical procedures.

One of the earliest complete medical records was written about 1500 B.C., and is known as the Papyrus Ebers. This papyrus was found between the legs of a mummy in a necropolis near Thebes in 1872, and was sold to a German archeologist named Georg Ebers. Thus the papyrus Ebers, which dates prior to the exodus of the Isrealites from Egypt, derived its name. It is written on a sheet of papyrus twelve inches wide, and one hundred feet long, and when found was rolled in a scroll. This record is claimed to show a careful observation of disease, and an intelligent application of remedies, one remedy being, "Berries of the castor oil trees: Chew and swallow down with beer in order to clear out all that is in the body." While this is not the most ancient papyri, nor the most ancient of writings, it is among the most ancient that can be termed a medical record.

As early as 1134 B.C. there was in existence near Athens, a temple for the care of the sick. This temple was dedicated to Aesculapius, the Greek God of Medicine, and was situated in the hieron, or Sacred Grove at Epidaurus. Other temples were also founded for the care of the sick, and throughout Greece these were known as Aesculapia. In the ruins of one of these temples columns were found with inscriptions attesting to the names of patients, brief histories of their cases, and comments as to whether or not they had been cured. These might well be termed medical records in the sense in which we know them today.

Hippocrates, best known as the "Father of Medicine," was born about 460 B. C. at Kos, one of the Grecian temples for the care of the sick. He became a priest-physician and was the author of the now famous oath dealing with the privacy of medical records. He wrote voluminously on subjects relating to medicine, and propounded many medical theories, hence his works have been translated into many languages. In his writings he described many conditions such as are existing even today, one such instance being, "If a dropsical patient be seized with hiccup, the case is hopeless." Of even more importance to medical records librarians is the fact that he kept detailed records of his patients which took the form of clinical notes. He also taught his sons Thessalus, Dracon, and Dexippus in the art of recording all findings.

During the time of Marcus Aurelius, a physician named Galen appeared in Rome, having made himself famous for curing the emperor. Galen was born at Pergamos, where Esculapian tablets were found,

and he also had access to the libraries at Alexandria. He had many pupils and took them with him on his visits, just as the doctors of today take the interns with them on their rounds, and founded his teaching on written records. In one of his writings he describes the pain felt in an attack of gallstones, describing it as radiating from the upper abdomen into the shoulder, a symptom used constantly for diagnostic purposes today. One of his writings in 130 A.D. was illustrated showing the taking of a history at the bedside of the patient.

About this time the Romans had a journal known as the Roman Acta Diurna. Accounts of the day's events were posted each morning in a conspicuous place in the forum, the accounts of a medical nature posted being analogous to that furnished by the medical correspondents of our papers today. The difference between the Roman Acta Diurna and the writings on the columns of the temples in Greece and Egypt being that while the information from the latter was found only in the temples and the sick and those who ministered to them were the only ones likely to be benefited by it, the former was given out to the public as public news.

The Dark Ages saw the rise of Islam. A knowledge of Greek existed among these peoples and so we have Arabian medical literature. Avicenna based his writing in medical science on the work of Hippocrates and combined it with medical information gathered in his journeyings as an itinerant doctor. This shows the use of clinical notes for the production of a treatise even as is done today.

With the decline of Greek and Roman civilization very little progress was made in the recording and preserving of medical records for many years, the only work being that done by the conscientious monks who copied by hand, and in that way preserved the writings of Hippocrates, Celsus, Galen, Avicenna and many of the other early physicians. While the art of medicine was cherished by the nuns and the monks, learning was not spread from the cloisters as it had been spread by the pagan temples.

St. Jerome conducted a hospital in 300 A.D. and wrote on medical subjects. He is credited by some authorities as having been the first to mention the word "hospital." This word is derived from the Latin "hospitalis," an adjective, and "hospes," a noun meaning a host or guest.

Vesalius is credited with making the first great contribution to anatomy, and this was made possible because he kept a record of his findings. Greek religion had prohibited dissection, as their religion was based on the belief that they would have a material resurrection, but Vesalius surreptitiously secured the bodies of criminals in order to study the human anatomy, and from this time on the structure of human bodies, rather than of animal bodies, was studied by dissection, and from this knowledge of anatomy they were soon able to study the functions of the human body also. Due to the fact that he realized the importance of recording his findings we have his "Fabrica," an anatomy published in 1543. He eventually became Professor of Anatomy at the University of Padua,

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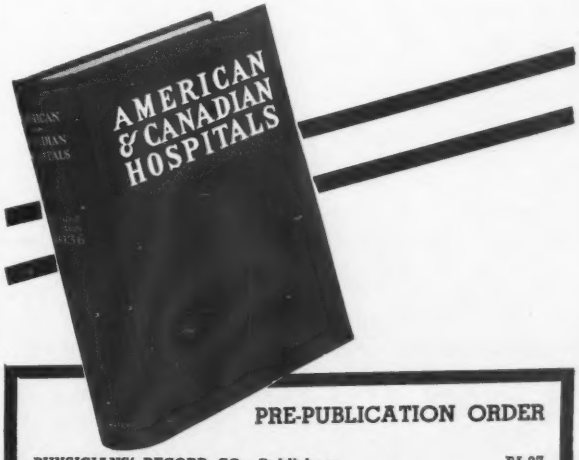

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The Medical Records Department as it is found today in the average Hospital.

being the first to hold that appointment in this university, which was one of the first in Europe to give instruction in the study of medicine.

With the renaissance of European civilization St. Bartholomew's Hospital in London, a well organized hospital of that day, realized the importance of keeping medical records as the following transcripts from their Book of Orders will show: "An order for the safe keeping of the evidences and writings appertaining to the hospital. There shall be one fair and substantial chest provided, and the same be set in the most convenient and surest place of the house, the which shall have III several locks, and III keys, whereof the President always to have one, and the Treasurer one, and a Commoner appointed by the whole house, to have a third. And it shall not be lawful to any of the Governors to have any specialty, evidence or writing, out of the said chest, neither any other person, to carry them out of the house (no, though it be for the affairs of said house), but only a copy thereof, which shall be taken in the presence of III persons above named, that have the keys, and the original to be forthwith locked up again." . . .

"And for the good order and governance of this house may better appear, as well to the governors now being, as to all other worthy personages that hereafter shall govern, or shall desire the certainty thereof, it shall be requisite that ye keep diligently IIII several books, the names whereof, and the use, are here described: A Reportory; A Book of Survey; A Book of Accounts; A Journal. And first you shall note, that before any of these books ye must have a Calendar, into which ye may enter, by order of the letters A.B.C. all proper names and matters, that shall be contained in every of them.

"And for the better accomplishing hereof, ye shall with your pen, in the head of the leaf, number the pages of the leaf, in every of these books, and then adding in your Calendar the number of the page, where the matter is entered in your book, the reader without any difficulty may turned to the same."

It was also required that a record be kept of all patients admitted to, and discharged from the hospital, and the deaths "together with the name of the shire wherein each was born, and their faculties (trade or profession), exercise or occupations." All patients were required to be examined by two of the surgeons, and if judged curable, then to "certify the name" of the patient to the Almoner, who in turn procured the signatures of the surgeons "to keep upon a file." Other interesting regulations specified that the names of discharged patients were to be "regeste into your book . . . with the day and year of their delivery and departure out of the house." Thus apparently St. Bartholomew's Hospital took the lead in establishing what would correspond today to a medical records library, just as in 1667 they took the lead in establishing a medical library.

The first study of vital statistics was made by Captain John Graunt in 1662, when he published his observations made upon Bills of Mortality, which included lists of burials, marriages and baptisms. In this study he pointed out several facts which are still in existence today, one being the fact that the urban death rate is normally higher than the rural, and the other being that even though the male births exceed the female, that there are approximately equal numbers of both sexes in the population, thus proving the high rate of mortality in the earlier years of life.

Benjamin Franklin was one of the principal factors in establishing the first hospital within the borders of the United States. This institution was known as the Pennsylvania Hospital and was established in Philadelphia in 1752. He served as Secretary of the hospital, and many of its earliest records are in his handwriting. For the first fifty years the only medical records kept were the Register in which was recorded the name of the patient, address, disorder, dates of admission and discharge, result, and the patient's security. This information has been preserved from the first admission to the present time. "In 1803, the Manager ordered that a detailed record be kept of interesting cases. This was done, and very interesting records they are, a number being illustrated with pen and ink sketches." In 1873 the histories were required, and the file is unbroken to the present day. The first Patient's Index was started in 1873, although there was no card catalogue until 1906.

In 1811 the famous Massachusetts General Hospital opened. It lays claim to being the first hospital in the United States that can boast of complete clinical records from the day it opened, with all catalogued, although they did not have a card catalogue until 1872. Their old records were written in ink made at the hospital, and it is legible to this day. During the early years the histories were written in folio volumes, 18 inches high, 12 inches wide, and 2½ inches thick, bound in boards covered with dark red leather, tooled in gold, and weighing at least ten pounds each.

The terminology of that early day seems very strange to us now. Mrs. Grace W. Myers, Librarian Emeritus of Massachusetts General Hospital, relates the following as found in the record of the first case of major surgery entering that hospital on September 28, 1821. "Memoranda of Articles, Etc., to be in readiness for the operation. Among them are, 'oil, ice, warm and cold water, warm barley water, wine and water, blood catchers, five aids, basins, coat' . . . Next the instruments are listed; then that the patient is to be prepared for the operation of lithotomy.' 'Arrangement' follows this, i.e., the placing of patients, assistants, etc.

Then the method of operation; dressings; 'accidents to be avoided'; and caution to 'aids.' Everything went well and on December 17 is this note: 'He is discharged to leave the house whenever he pleases.'"

Another interesting account is taken from a record of a case of "Pneumonitis": "'Night comfortable; refreshed by sleep; flesh gratefully warm; pulse 72. less full; calm; countenance improved.' 'Desire for tea and crackers; take some.' 'Hunger continues; . . . milk porridge instead of tea.' 'Take meat for dinner with one-half pint of beer.'"

A preoperative note very different from that found on our present day surgical records states: "Operation by Dr. Warren at 22 2/3 o'clock." The patient was described as being "excessively apprehensive of evil, asks for opiates before operation." His request was granted and the order given for "Tr. Opii XL gtts. at 11, and repeat at 11½ a.m."

Among the interesting diagnoses encountered in that early day Mrs. Myers sites the following: "Squeezed Head," "Whistle in the Esophagus," and "Wild Animals in the Blood."

It can readily be recognized by following this article through, that the keeping of medical records in the past has not been a unified effort. Those physicians and hospitals interested in the study of medicine kept such records as would meet their needs, while the great majority kept no records at all.

Since 1918, when the American College of Surgeons inaugurated a movement known as Hospital Standardization, and adopted as one of their minimum requirements ". . . that accurate and complete case records be written for all patients, and filed in an accessible manner in the hospital," there has been a steady improvement both in the quantity and in the quality of medical records, as the hospitals soon realized that it would be impossible to secure approval until they made an effort to fulfill the requirements of the Minimum Standard.

Then, when in 1928 the group known as The Association of Record Librarians of North America was organized, another forward stride was taken. This new organization took as its object, "To elevate the standard of clinical records in hospitals, dispensaries and other distinctly medical institutions." Thus, the combined efforts of the three leading organizations of the medical world, the American Medical Association, the American College of Surgeons, and the American Hospital Association supported by the efforts of the Association of Record Librarians of North America, should keep the thread of medical records, upon which medical knowledge is based, unbroken to the end of time.

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Business Methods . . .

(*Continued from page 21*)

of a community adopt a uniform schedule of charges. It would be most advisable to standardize charges, provided the hospitals give a comparable type of service.

3. What is the most practical admitting procedure with regard to financial arrangements? Is it advisable to have a separate credit department?

The patients who incur accounts for care and treatment in church or community hospitals comprise every type of credit risk, which tends to make collection efforts most difficult. In order to show the maximum of results an efficient admitting department is essential, as the most important part of the collection procedure is the interview on admission, when the information concerning the paying ability of the patient or responsible person is secured.

These results can only be obtained when this department is an integral part of the business organization. The question of properly handling people who are about to incur hospital accounts is very largely a matter of education and practice. Authorities on hospital administration are inclined to favor the graduate nurse as admitting officer. While not arguing against this, I have found that a successful procedure is to have a lay-person, whose qualifications include a thorough business training as well as a broad understanding of human psychology, working in collaboration with a graduate nurse. The admitting officer can, with a great degree of certainty, foresee what may be expected in respect to settlement of an account when all pertinent data has been recorded on the admittance report. This information is also a means to allocate a patient to the proper type of accommodation. It is, however, most advisable to begin investigations as to the financial status of the patient as soon as the doctor makes reservations. This may be done through a credit rating service or, when possible, obtained from the financial records of previous admissions. Quite frequently doctors co-operate with the hospital by referring prospective patients to the credit department when there is any question regarding their ability to pay. The report of the admitting officer should be checked by the credit manager the day after admission and filed in a "tickler" file for follow-up purposes during the patient's stay in hospital. Upon discharge the patient who is about to leave with an unpaid account is referred to the credit department, at which time arrangements made on admission are confirmed or adjusted. The duties of the personnel in the collection organization so correlate with those of the general business organization that it is not practical to set up a credit department separately. It is most advantageous to have a full-time solicitor in the business organization, as he will be able to give his attention to accounts where legal formalities have to be complied with and also enforce collection of accounts when debtors try to evade payment of their obligations.

ANESTHESIA, PATHOLOGY, X-RAY

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CONTRIBUTING EDITORS

THE ANESTHETIST'S NOTEBOOK

This is the fourth of a series of discussions of the problems and theory of present-day anesthesia administration and practice. Individually, these discussions will furnish welcome guidance for every practicing anesthetist and student-anesthetist. Collected in notebook form, they will comprise a valuable handbook for everyday use.

Respiration, in a broad sense, includes not only the processes by which Oxygen is brought to the tissue cells and Carbon Dioxid taken away, but also the means by which this gaseous exchange takes place within the cells. The respiratory system is the portal of entry for the general inhalational anesthetic. Although it is only one-third of our pattern, often when it is the only part of the pattern available for the anesthetist to study, great dependence must be placed on it. This occurs not infrequently in the dark room and with such operations which necessitate concealing the patient by drapings.

It is imperative that the anesthetist be as familiar as possible with rhythm and depth of normal breathing as applies to various sizes and ages of patients. This knowledge is gained best by studying one's own respiration, that of his co-workers and the normal of the patient while he is still awake. Further study in the changes caused by premedication must be taken into account, and with this preliminary data the rhythm and evaluations of the changes of the anesthetized patient are much more accurate.

Presuming the apparatus is checked, and there is sufficient gas in the bag for a complete inhalation by the patient, the patient is instructed to breathe about the way he would breathe "if he went out to the park for a walk" and the mask is put on with a gentle but firm slipdown motion. The bag will be noted to expand and contract, and valves, if metal, will be heard to click in rhythmic accord to the breathing. Here the first real check on the volume of breathing of a patient is noted, and should be carried as a mental picture throughout the operation. At the point where the patient slides into the anesthetic state, there is a general readjustment of the physiology and the patient ceases to influence his type of breathing and he assumes a rhythm characteristic to himself in this new state. It varies slightly with each patient and is more or less characteristic for each anesthetic agent. When ether is added there may be, at first, a sudden hold up in respiration and even coughing if the ether is added without care. This is followed by a respiratory stimulation and the characteristic ether snore. If ether is withheld and the gas mixture is constant, the respiratory rhythm remains as it was at the beginning, varying only with changes in Carbon Dioxid concentration.

Cyclopropane does not follow the respiratory pattern of the other gases with which we are acquainted. With this gas the respirations approach more closely the slow, soft breathing of chloroform. We will discuss our first two thousand cases of Cyclopropane anesthesia at a later date.

Some patients breathe more or less normally through habit when awake only to become definitely "poor breathers" under the influence of anesthesia. This small group of patients may cause the anesthetist no slight degree of anxiety. However, irregular, shallow, or halting breathing may be perfectly normal for these patients under anesthesia. This seemingly dangerous breathing may cause the surgeons and attendants a great deal of distress. It is regrettable and often serious for the outcome of the technical part of an operation if the management of the breathing is not handled by a capable and trusted anesthetist, leaving the surgeon to do his work and the anesthetist to evaluate and conduct the anesthetic.

Before doing anything for a "poor breather," we must make sure that there is no obstruction in the air passages. We know that patients with depressed respirations under morphine, for instance, do well when breathing at a rate of six or eight times per minute. The first question that arises is—is the patient breathing sufficient volume to live if he were breathing fresh air? If so, there is little reason to worry. If not, immediate treatment is necessary such as increased

By BEN MORGAN, M.D.

concentration of Oxygen and addition of Carbon Dioxid. Should this treatment be inadequate, a more serious condition is at hand and should be vigorously dealt with. The general outcome of these patients is usually uneventful, leaving behind only the memory of this worry.

At any time during an anesthetic, cessation of respiration may occur, usually temporary and uneventful. When this happens, diagnosis of the condition should be made by the anesthetist as soon as possible. The following diagnostic points are of immediate consideration:

(1) Obstruction to the respiratory tract; (2) Sudden addition of Oxygen; (3) Sudden addition of Ether; (4) Too light anesthesia; (5) Too deep anesthesia; (6) Sudden change of position of patient's body; (7) Manipulation by surgeon.

These conditions are readily treatable. The more serious conditions suddenly appearing might be:

(1) Fibrillation; (2) Coronary occlusion; (3) Bolus of food or other foreign matter causing obstruction; (4) Collapse of trachea; (5) Paralysis of vocal chords; (6) Disturbance of respiratory center; (7) Recurrent laryngeal nerve injury; (8) Folding in of alli of nose after anesthesia relaxes the muscles. (This is to be noted on especially thin noses.) (9) Pulmonary embolus; (10) Collapse of lung from mucous plug in large bronchus; (11) Lack of normal Carbon Dioxid in blood stream, particularly found in open ether anesthesia where not sufficient rebreathing is used.

The Anesthetic Service should provide for these emergencies with the following: First—A suction pump for aspiration is indispensable and should be readily available. Second—The stimulants should be grouped and their physiological action thoroughly understood by the anesthetist. Third—Collapse of the trachea may be corrected by position of the head and neck but, like collapse of the vocal chords, may necessitate introduction of a tracheal catheter. The Laryngoscope is the method used by the writer. Spasm of the muscles of the jaw may render the use of the Laryngoscope impractical and the nasal catheter method must be substituted. Collapse of the lung by a mucous plug may necessitate bronchoscopy. Fourth—Helium may be used to aid in carrying Oxygen through obstructed airways to the air cell when ordinary means such as pressure on the bag and artificial respiration fail.

It is the general custom at the end of a gas anesthetic to flush the patient with Oxygen. This practice is commendable, but should be done with the 30-70% mixture (30% Carbon Dioxid—70% Oxygen), thus avoiding the headaches which frequently follow. In the last four years we have established in many hospitals the routine cupping of a towel over the face *immediately* upon removal of the mask. This towel is kept in place until the patient awakens. The advantages have been found to be twofold. First, the exhaled Carbon Dioxid is utilized by the patient. This is a mild stimulation and can be used over long periods. Second, the post anesthetic nausea is reduced at least 50%. The mild stimulation of breathing by the accumulated Carbon Dioxid promotes elimination of anesthetic material and returns the patient more quickly through the spasm zone to normal.

The New Partner . . .

(*Continued from page* 51)

ple. We feel that seventy-five dollars a month and full maintenance is a minimum salary, which should only be offered to a beginner in an assistant's position, and that this rate should not be continued over a long period. It is entirely inadequate for a professional worker carrying the responsibility for a department. It will pay you to start your dietitian at a hundred dollars or more. Compare your dietitian's salary with that of the head of your other major department, nursing, not with that of general duty nurses. Incidentally, it is ridiculous to pay the dietitian no more than the cook whom she supervises.

What do we mean by the term "qualified dietitian"? Dietitians are not registered. There are no legal standards which they must meet. The hospital superintendent must therefore scrutinize their credentials doubly carefully. Standards have been set up by the American Dietetic Association which include four years of specified university work and a graduate year in a hospital course approved by the Association. Details of these requirements can be secured upon request, if the superintendent wishes to check the educational qualifications of applicants himself, but as this is rather a complex undertaking it is probably wiser as well as easier for him to ask either the placement bureau of the American Dietetic Association or the head of one of the approved student courses in whom he has confidence, to recommend suitable candidates from whom he can choose one with the personality and experience he feels his institution needs. The dietitians available for positions in small hospitals are for the most part young, but they will do a piece of work that may surprise you. They are being better trained than they were a few years ago. The graduate of an approved course for student dietitians today knows things about her business that formerly took years of experience to learn.

The small hospital needs a dietitian, and will usually find it advantageous to put her in charge of the housekeeping department as well as the food. She needs the part-time assistance of a clerk to relieve her of clerical routine and to make possible the keeping of administrative records. When the hospital has more than fifty patients she needs an assistant as well. She must have an office suitable to her rank as a department head, in a position easily accessible to staff doctors. She should be held responsible for and given authority to carry through the whole function of her department; hiring and control of personnel, purchasing of supplies, food preparation, and service to both patients and personnel. She should originate the department budget, since she is the person with the most intimate knowledge of the needs of the department. She will not be found lacking if she is made to feel that she is a part of the hospital administration. The old firm of hospital superintendent, business manager, and superintendent of nurses, must admit a new partner.

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West Jersey Homeopathic Hospital,
Camden, N. J.

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Fairmont Hospital
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CONTRIBUTING EDITORS

Program Announced for Fourth N.E.H.A. Congress

» » Final arrangements have been made for the Fourth Annual National Executive Housekeepers' Association Congress, to be held May 20th to 23rd at the Hotel Hollenden, Cleveland, Ohio.

The program for the four-day session is as follows:

Thursday, May 20th, 10:00 a. m., registration and informal gathering; 12:00, luncheon; 12:30 p. m., national broadcast over WTAM. 1:30 p. m., visit to Cleveland (Lakeside) and St. Luke's Hospitals, with a reception and tea at St. Luke's Hospital at which Mrs. Martha Wodehouse, vice president of the Cleveland Chapter, will act as hostess and Dr. Charles S. Woods, superintendent of St. Luke's Hospital, as host. 2:00 p. m., executive board meeting; 7:30 p. m., President's Dinner for active Chapter presidents.

Friday, May 21st. 10:00 a. m., business meeting; 12:30 p. m., luncheon; 2:00 p. m., business meeting. Speakers—Miss Hortense E. Wickard of Association of American Railroads Equipment Research Division, who will speak on "Home Comforts in Hotels on Wheels," and Miss Olive W. Dennis of the Baltimore and Ohio Railroad Co., who will discuss "Housekeeping Problems on a Railroad." 6:00 p. m., trip to Nela Park for dinner, inspection of cafeteria kitchens. Speakers—Karl Hertel on "Lighting Magic," and E. W. Commery on "Lighting the Hotel Guest Room."

Saturday, May 22nd. 10:00 a. m., business meeting; 1:00 p. m., luncheon; 2:00 p. m., national board meeting to select national officers; 2:30 p. m., business meeting; 7:30 p. m., banquet and dance in the Hotel Hollenden Ballroom, with Theodore DeWitt of the DeWitt Hotel Co., acting as toastmaster.

Sunday, May 23rd. 11:00 a. m., brunch; 12:30 p. m., national board of directors' meeting; afternoon open.

Purchase and Care of Wet Mops

» » There are four main points to be considered in the purchase of wet mops. First, power of absorption; second, rinsing qualities; third, tensile strength, and fourth, uniformity.

A good grade cotton mop will absorb three times its weight in water after the first soaking. This is not on the basis that a pound of cotton will pick up so much water, as the way cotton is twisted has considerable bearing on its powers of absorption and also its ability to dry quickly without developing odors. A mop that has been thoroughly soaked and used for two or three days will absorb more water and do better work than a new one.

The cotton must also rinse freely or it will be impossible to mop a floor clean. Not more than one-half the weight of the mop in water should remain after the mop is wrung out. If more than this remains, there is dirty water in the mop.

When the mop is in a wet condition try to break

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one of the strands. Poor tensile strength in a mop is responsible for the residue left on the floors. Also these pieces of mop cotton will close pipes in service sinks and make extra repair bills. However, mops are not always worn out on the floor. There are types of mop wringers which are very hard on mop strings. A mopper puts his whole weight on a foot power wringer and jerks the mop up through the rollers. This treatment will pull out any strand which is a fraction longer than the others. A wringer which rolls the mop as a clothes wringer does will mean longer wear on mops.

Also the type of mop handle affects the life of a mop. Where the mop is strung through the metal part of the handle, there is a hard surface bearing down on the floor, which will soon wear off the outside strands. A wide tape head will help this condition but a metal outside grip handle is best.

Men prefer large mops with small heads and an even thickness so that the whole surface of the mop is on the floor. Girls can work more quickly with a smaller, lighter weight mop and also require a mop handle of smaller diameter so that so much strength need not be used to grip the handle but can be used for the cleaning operation.

Uniformity can be secured by buying from a reliable concern, so that the same type mop can always be secured.

Good grade mops are made of long fibre cotton bleached to remove seed oil. A cheap mop is solid grey or streaked with grey which indicates a mixture of short fibres and waste with only enough medium fibres to hold them together. Short fibres always have particles of seed hull left in the yarn.

Wet mops can be successfully laundered by the regular washing formula; this will add much to their life and appearance. Do not force a mop dry by heat or let it freeze. Always shake well to separate strands and stand with head up so that air can circulate around it.

Questions on Housekeeping

By DORIS L. DUNGAN
Executive Housekeeper, West Jersey Homeopathic Hospital, Camden, N. J.

Question—

What are the essentials of a good housekeeping department?

Answer—

The essentials of a good housekeeping department are first of all a housekeeper who is a good executive. It is not enough for a housekeeper to keep the institution clean. As important as that part of her duties is, an intelligent maid could make inspections and supervise cleaning. The housekeeper must be an organizer who can put her department on a sound working basis; a buyer who knows how to balance price and quality against a sound technical knowledge of products used in her work. She must have the ability to manage her employes and cooperate with other department heads.

A working knowledge of psychology helps her to develop the knack of getting the most out of each employe and of getting and giving the utmost cooperation in dealing with fellow executives. The knowledge helps her to foresee the result of her own actions and to gauge them to bring responses that promote harmony. She must have some knowledge of interior decoration. Make no mistake about the necessity of the all-important feminine touch in a hospital. A picture or a bowl of flowers beautifully arranged may do much to create an atmosphere of home. The housekeeper is one of the most important personal relations contacts in the institution, even though she may not meet the public directly, as the work of this department is everywhere in evidence. A housekeeper with imagination and enthusiasm can overcome the handicap of an inadequate working force and stretch dollars for supplies and decoration to twice their usual size.

The second essential is a superintendent who having secured a good executive housekeeper allows her to run her own department.

Question—

To whom is the executive housekeeper responsible?

Answer—

The housekeeper should be responsible directly and only to the administrator of the hospital, since housekeeping is an administrative department.

Question—

What personnel is under the supervision of the Executive Housekeeper?

Answer—

The personnel responsible to the housekeeper includes assistant housekeepers, all linen room employees, floor and chamber maids, lounge attendants, porters, housemen, wall and window washers, floor polishers, sometimes elevator operators, yard men and painters. The laundry is often under the supervision of the housekeeper.

Question—

Should a head nurse be held responsible for the cleanliness of her division?

Answer—

A head nurse should not be held responsible for the cleanliness of her division when a housekeeper is in charge. However, when student nurses have some housekeeping duties, the head nurse is responsible for their work. The head nurse is sometimes in charge of ward maids or nurses' helpers. She can do a great deal to facilitate the work of the housekeeping department by checking untidiness in student and special nurses.

Question—

To whom should inefficient maid service be reported?

Answer—

Inefficiencies in maid service should be reported directly to the housekeeper. It is unnecessary red tape and highly expensive waste of time of the Administrator or of the Director of Nursing to send reports on maid service through their offices. Since the housekeeper must handle the matter eventually, it would seem reasonable to report such matters directly.

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Welfare Island . . .

(*Continued from page 25*)

2. *Industrial Arts and Crafts and Profit Activity.*—These are the people specifically in the Occupational Therapy Department and who do the weaving, basketry, rug-making, leather tooling, and whose articles are put up for public sale. The blind and the crippled are usually to be found in this group.

3. *Rehabilitation and Therapeutic Activity.*—Occupational work done for therapeutic purposes. The institution provides the materials necessary but no sale is held nor is any profit accrued. It is the group recommended by the doctor for therapeutics and which is taught some form of arts or crafts and may later develop into the group which works for compensation.

4. *Sewing, Mending and Manufacturing Activity.*—This group sews and mends for the benefit of the institution. Sheets, pillow cases, underwear, dresses and linens are mended. Curtains for institutional use are made and bandages and dressings for the hospital are cut. The men make brooms, brushes and mops, and repair mattresses.

5. *Occupational Work of Self-Benefit Activity.*—This group is taught to make things for themselves—spreads for their beds, covers for their chairs, window-boxes, curtains for their windows,—things in which a real personal interest can be taken.

6. *Occupational—Community Work Activity.*—This group undertakes to do work for sister charitable organizations, such as the Red Cross.

7. *Occupational-Recreational Activity.*—This group, together with the Recreation Department, makes props and costumes for the drama group; shelves, bookcases, for the library group; music stands for the orchestra, working and doing things without compensation for the various groups in the recreational department.

8. *Occupational—Morale Activity.*—Many carpenters, printers, gardeners, masonry workers, artists, etc., are in the institution and seem eager and anxious to do something which they have been accustomed to in their lives outside the institution. In an institution like the City Home and especially among the aged, the privilege of being allowed to work in familiar occupations can be the incentive for the finest morale. Accordingly, placement in work is as much in accordance with aptitude, inclination and past occupation as possible. This phase of our program led to the development of a semi-monthly newspaper called *The City Home News*, edited and printed by the old folks themselves.

The report of our Occupational Therapy Department for 1936 will indicate, I am sure, the extent of the work done and the results of our program. The total cash receipts of articles sold were $2,047.53 and the disbursements for materials, labor, entertainment, etc., were $1,688.58, leaving a balance of $358.95 at the end of the year. During the year, 2,617 articles were made for sale and 1,857 of them were sold. In the mending and sewing rooms, the old ladies of the home repaired 24,862 various articles of linen, underwear, dresses and sheets, and manufactured 7,340 new items such as aprons, laundry bags, curtains, chair covers, binders, glove covers, potholders, and crash towels. The men helped in remaking 252 mattresses and 540 corn brooms and brushes.

Interest, naturally, at this point tends towards the payments made to and the methods of paying those who work for the institution and those who work directly in the occupational therapy department producing salable articles. As stated previously, the men who work for the institution receive extra tobacco and the women sugar and tea. Those who make salable articles receive 50 per cent of the selling price of their article after cost of material is deducted. The other 50 per cent goes for replacements of equipment and materials, and also treats, entertainments, and small sums to those who do not make salable articles.

Permit me to conclude with this statement. After you have devised a workable program for your own individual institution and are ready to put the program into force, secure a capable, efficient, skillful and sympathetic director of occupational therapy. Let her pick her staff as patiently and as assiduously as you chose her. Give her full power to carry out your program, encourage her initiative and give full heed to such recommendations as she may make to advance your program and her work in the interests of the patients and guests.

Care of Indigent Patients . . .

(*Continued from page 23*)

Any regularly licensed physician may order a county indigent patient into the hospital. Immediately on admittance a report is made out and forwarded to the welfare department of the county. A personal investigation is made by a special investigator from this department. The special investigator either approves or disapproves the application. If approved, the hospital bills the county for the account at the regular rate according to the service provided. Funds for the payment of such accounts are provided by the county from county taxes.

City indigent patients are handled in the same routine as county indigent patients. Any regularly licensed physician may order a city indigent patient into the hospital. On admission of such a patient, the hospital contacts the welfare department of the city. A personal investigation is made by a special investigator from the welfare department. This investigator either approves or disapproves the application. If the application is approved, the account is billed direct to the city welfare department. Funds for the payment of these accounts are provided by the city from city taxes.

The plan provides for a fair distribution of the cost of hospitalizing indigent patients, the state paying its portion from the state funds, the county paying its portion from county funds and the city paying its portion from city funds. The fact that the hospital providing the service may be a public hospital or may be a voluntary hospital does not affect the program.